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ORIGINAL ARTICLES.

VENTILATION OF SOIL AND WASTE PIPES AND UNDER-DRAINS.

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ERROR REGARDING THE SOURCE WHENCE SEWER GASES ORIGINATE.

It is a common belief that the sewer gases in houses are, for the most part, formed in the large sewers or street drains, where they are supposed to accumulate, and by expansion, are forced backward into the dwellings. Hence many property owners, overlooking the principal source of danger, believe they and their tenants are afforded ample protection against the ingress of sewage effluvia by the insertion of a suitable trap in the drain leading to the street sewer.

GREATER DANGER FROM GASES FORMED IN SOIL AND WASTE PIPES WITHIN THE HOUSES THAN FROM THOSE GENERATED IN STREET SEWERS.

It is found, however, by many sad experiences, that a prolific source of danger arises from the putrefactive decomposition of matter deposited on the inner surfaces of the waste pipes within the house, a short piece, only a few feet in length, being frequently sufficient to contaminate the air in any ordinary dwelling.

The process of decomposition is greatly accelerated by the heat of the house. While, however, its formation cannot be entirely arrested, its accumulation and concentration can be effectually prevented, and its noxious properties neutralised and rendered comparatively harmless, by the admission and free circulation of outside air upward and downward through the pipes. The heat of the house in winter causes a rapid upward flow, and in summer, on account of the relative coolness of the inside of the house, the currents generally flow downward.

THE ONLY EFFECTIVE REMEDY—VENTILATION BOTH UPWARD AND DOWNWARD.

This combination of self-ventilating soil and drain pipes, illustrated by the accompanying diagram, constitutes a perfect protection against the formation and ingress of foul gases into dwellings.

The following extracts in quotations contain many practical statements regarding the sources of danger and also the best methods of avoiding them, the only weak point therein being that the author takes the supply of fresh air from the cellar of the building. It is, without question, a better plan to place the short ventilating pipe out of doors.*

A SMALL SECTION OF UNVENTILATED WASTE-PIPE SUFFICIENT TO CONTAMINATE THE AIR OF ANY DWELLING.

"The true source of this evil is to be found in the *drain pipes* of the house itself, whose interior surfaces are coated with fermenting matter deposited there from the fluids and solids which pass through them; and so great is the productive power of these coatings, that *less than one-half of a square* foot of the interior of a pipe, which never had anything in it except the discharge water from a bath-tub in use about six months, will generate enough sewer gas to render a house unfit to occupy."

CARE REQUIRED REGARDING DISCHARGE PIPES FROM BATH TUBS.

"As usually constructed, bath-tubs are provided with an overflow-pipe, leading out from the tub near its upper edge, through an opening in the metal which is covered by a stellated shield. This pipe joins the discharge-pipe, passing out from the bottom of the tub and leading to the soil-pipe; and a trap is then placed in that pipe just beyond the junction of the two. When this trap is filled with water, communication is intercepted between the bath-tub and the soil-pipe, but there is an open communication from the discharge aperture in the bottom of the tub through the overflow-pipe to its aperture near the top of the tub, so that air can be circulated through this passage. By applying to the discharge opening in the bottom of the tub an India-rubber tube, or any other convenient pipe, and blowing through it with the breath, the gaseous contents of this overflow-pipe will be driven out through the overflow aperture, *and the sickening odor which will be perceived will demonstrate the existence of sewer-gas in these pipes.*"

MINUTE VEGETABLE ORGANISMS.

"I have examined the interior surfaces of these discharge-pipes, and find them coated with extremely minute vegetable organisms, not observable by the naked eye, but very distinct and well defined under a microscopic power of about two thousand diameters."

WASTE-PIPES CLOSED AT THE TOP ARE PROLIFIC GENERATORS OF SEWER GAS.

"As the plumbing in houses is generally organized, the great amount of sewer-gas generated at the surfaces of the entire system of pipes forces its way into the house; because the whole pipe system is closed up inside of the house, except where the basins empty into it, and a deep trap is placed at the lower end of the soil-pipe, and between the house and the sewer. As the gas is generated in this ramified retort, it must either force its way out through the street trap, or through the feebler basin traps of the house, or through defective joints in the plumbing work; and, inasmuch as the street trap resists the most, *the gas goes into the house.*"

THE OPEN SOIL-PIPE INSUFFICIENT.

"If, however, the pipe system is open to the air through the roof, as it is now frequently made, then the excess of generated gas, after the pipes are fully charged,

* "Sewer-Gas in Houses: Its Origin and Prevention." By E. N. Dickerson. *New York Med. Jour.*, April, 1879.

will pass out from the opening above; but the pipes themselves will be still fully charged with sewer-gas, which is constantly being supplied from the fermentation going on everywhere in the system, and it will escape through any openings into the house, and will diffuse through the water of the traps, even though all of the pipes are in communication with the soil-pipe opening at the roof. What escapes from the opening at the roof is obviously only the excess which is generated momentarily, just as steam blows out at the safety-valve while the boiler is fully charged. How much this amounts to in any house may be estimated by going on the roof and observing the action at the aperture of the soil-pipe in a case where there is a street trap cutting off the sewer, and where, therefore, all that escapes at the roof is momentarily generated in the house itself. The odor which is diffused through the atmosphere for a considerable distance from the pipe aperture is sickening; and one whiff of it in its concentrated form, as it escapes from the pipe, will nauseate a strong stomach, and generally produce stricture at the forehead and headache, thus showing its effect upon the human system."

TWO TRAPS IN THE SAME PIPE A FRUITFUL SOURCE OF MISCHIEF.

"But, generally speaking, and in all cases where I have examined the construction in large houses, there are considerable lengths of waste-pipes which lead from wash-basin traps into water-closet traps, and which therefore, are not in direct communication with the soil-pipe. This construction is preferred by plumbers, because, under the theory that 'sewer-gas' comes from the sewers, and must be intercepted in its passage to the basins, this arrangement supplies *two traps* instead of one, and therefore makes it certain that no street sewer-gas will force its way through both, even if it blows in through the street trap. In these double-trapped drain-pipes all the gas that is generated is under pressure, and it escapes through the weaker basin in bath or wash-basin traps, although there may be no pressure in the soil-pipe itself beyond the second trap. *These pipes are a fruitful source of sewer gas in houses.*"

BASIN WATER-CLOSETS ALWAYS DEFECTIVE.

"Basin water-closets, also, are prolific sources of gas under any possible system; because the trap under the basin is always charged with excrements, and the fermentation which occurs from the basin side of the trap must necessarily expel the gas, either through the water-seal in the basin, or out of the open hole in the hopper through which the spindle that works the basin passes. These closets are an abomination under any circumstances, and should be always removed and substituted by some of those closets of the Pierson type which have no traps, and in which an India-rubber-seated valve closes the passage air and water-tight, and is covered by a water-seal."

THE ONLY EFFECTUAL REMEDY—VENTILATION BOTH UPWARD AND DOWNWARD.

"The true remedy for all these evils, and it is entirely effectual, is to reduce by exhaustion the *pressure in the soil-pipe below that of the atmosphere*, at the same time supplying the soil-pipe at its bottom with fresh air.... constantly flowing through it, whereby all the gas generated in it is diluted and swept away as fast as it is made, and the interior of the pipes is dried by the fresh air flowing in below, and as a consequence fermentation is arrested for want of moisture, one of its essential conditions.

OTHER PRECAUTIONARY MEASURES.

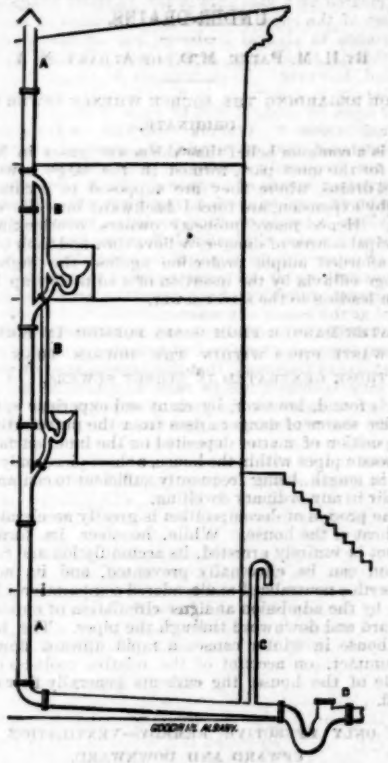
"Then see to it that all the drain-pipes leading into this soil-pipe from the wash-basins and baths have only one trap in them, and that one *as near as possible to the bottom of the wash-basin or bath*; and that there are no traps under water-closets in which to store excrements; and no overflow-pipes, such as described above, to the bath-tubs; and the house will be effectually protected against sewer-gas."

PRACTICAL RESULTS OF SOIL AND WASTE-PIPE VENTILATION.

An examination of waste pipes, after a few weeks' trial of this improved system of ventilation, shows previous accumulations to have been greatly reduced in quantity and changed into inert carbonaceous material.

HOW TO DETECT DEFECTIVE JOINTS IN THE SOIL-PIPE OR DRAIN.

An effective method of ascertaining whether gases are escaping from any portion of the pipes or drains into the building is, the pouring into the soil-pipe at its highest inlet, an ounce or more of the oil of peppermint. If there are any defective joints either above or below the surface, the odor of the oil will speedily reveal them.



EXPLANATION OF THE DIAGRAM.

A. A., Self-ventilating soil-pipe, passing, of uniform size, out above the roof, providing for free ventilation upward.

B. B., Air tubes connecting with the soil-pipe above the water-closet, to prevent drawing out of the water in the traps by suction.

C., Short ventilating tube outside of the house, opening a few inches above ground, to secure thorough ventilation of the soil-pipe and drain downward.

D., Trap in the main drain outside of the house, and beyond the short ventilating pipe, to prevent ingress of sewer-gas from the street drain.

ON THE PERFORMANCE OF PERCUSSION.*

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Of all the advances in physical diagnosis which have been made since the discovery of the art, the most important is undoubtedly the discovery of mediate percussion by Piorry of France, and its substitution for the old or immediate method, in the early part of this century—a change which at once enabled many obscure physical signs of disease to be distinctly defined, and rendered them of immensely greater value to the practicing physician. The actual worth of any diagnostic sign obviously depends upon the ability to distinguish it with ease and certainty from all others; this, with regard to any but the most pronounced, cannot be done by immediate percussion—by direct blows upon the body of the patient.

A discovery, like that of mediate percussion, which at once cleared up a vast field in the physical diagnosis of diseases of the chest and abdomen, becomes of immense importance to clinical medicine, but on one condition, viz., that it comes into general use. Is that condition fulfilled, however? Is percussion in frequent use by practioners in general? Is it uniformly employed and relied upon by medical men in cases of thoracic and abdominal disease? I think everyone will agree to the statement, that, as a rule, the general practitioner does not frequently employ or rely upon percussion as an important means of diagnosis. To anyone who is in the habit of employing and trusting it, this will seem a serious loss, a loss to practical medicine, moreover, which we should make a constant effort to diminish. The present paper simply hopes to be a contribution to that end, by striking at one great cause of this neglect, viz., the present difficulty of acquiring the art of percussion except at the hands of a master.

This difficulty, we believe, can be so far diminished by the employment of a form of hammer which is in extended use in Germany, that the performance of percussion may become quite as easy as auscultation. The other great cause for the lack of employment of percussion by the profession in general, is doubtless the fact that, until recent years, the art of physical diagnosis has not been taught at our medical schools. The act of percussion seems so simple, however, that few medical men, whether trained or not in its use, will refuse to percuss when called upon to do so; yet a very large number by their very first stroke will show their practical deficiency—a fact quite forcibly indicated by Flint.†

"It is generally easy to know at a glance by the mode in which percussion is made, whether it be resorted to in order to develop physical signs with the import of which the practitioner is practically familiar, or whether it be employed merely for forms' sake or to affect an acquaintance with the subject."

As the mere pounding with the fingers appears to be so simple a matter that no special practice seems called for, poor results upon percussion are apt to be attributed to a lack of discriminating power on the part of the ear, rather than to a deficiency in the manual part of percussion. This undoubtedly leads, in many cases, to an infrequent recourse to this method of exploration, and renders many diagnoses uncertain or erroneous that might be positive. From unfamiliarity with its performance, the results when employed will be uncertain.

As the number of signs to be obtained upon auscultation and the difficulty of distinguishing between them is as great or greater, than with percussion, we must attribute the less frequent recourse to percussion to the difficulty of obtaining those signs, rather than to difficulty of discrimination.

It may be stated as a general truth, that if we percuss well we will very soon learn the physical characteristics of the three fundamental sounds to be obtained upon percussion; but if we do not percuss well, discrimination between them and their combinations will be difficult and uncertain.

It is a fact, often verified, that a student can learn the simple art of percussing with his fingers in one lesson. It is also a fact that all his teacher need do, is to *tell* him how to place and how to use his hands and fingers; the personal example of the teacher, although a quicker means of instruction, is not a necessity in order to convey an idea of how to bring out true and uniform sounds.

There lies no great inherent difficulty in acquiring the power to properly percuss; anyone with ordinary dexterity, we may say, can easily acquire the correct use of the fingers by half an hour's practice, if he closely follow the rules contained in any of the prominent works on the subject of diagnosis.

These rules are few and may be briefly stated:

1. Employ a free, swinging, wrist motion with little or no movement at the elbow.

This rule is absolutely necessary to follow, in order to obtain results in any degree positive or uniform, and by uniform results are meant uniform sounds upon striking any one spot. Nothing is so confusing, and nothing is so frequent with beginners, or others unskilled in percussion, as to get two different notes at the same point. It is the wrist motion which gives the delicacy and precision to percussion as to other similar manual exercises such, for instance, as piano-playing.

2. Strike with the very ends of the fingers.

It is the non-observance of this and the preceding rule that brings the lack of positive results which has mainly rendered percussion so much less employed than auscultation, by those who have not had the advantage of being personally instructed in these particulars.

The more frequent recourse to auscultation than to percussion in general practice, may also be due to the trouble of having patients remove their garments, although anyone well versed in either branch of physical exploration will seldom, if ever, examine over more than a thin undershirt.

Beginners in percussion almost invariably strike with the pulps of the fingers. The wrist is held stiffly, and the blow is delivered from the elbow. *A priori*, a blow struck in this way would seem to be more forcible than one delivered merely from the wrist. A comparison of the two methods upon the chest or any resounding body, as a thin door panel, however, will abundantly demonstrate the immense superiority of the latter method, both as to loudness and clearness of resonance. The former method is incapable of results in any degree positive, and moreover is very tiresome.

3. To hold the finger receiving the stroke evenly in contact with the surface, and more or less firmly thereon, according to the depth of tissue which it is wished to examine.

Da Costa states that there is no more frequent mistake in percussing, than not holding the finger uniformly in contact with the chest wall, whereby the sound of the finger instead of the lung is obtained.*

4. Let the stroke be like that of a spring hammer, which rebounds as soon as it strikes. Holding the fingers of the two hands in contact will shorten and deaden the sound, destroying the resonance to a greater or lesser degree.

5. Become ambidextrous! Learn to percuss equally well with both hands.

This ability is quite indispensable in properly comparing the resonance of the two sides of the chest at the outer ends of the infra-clavicular spaces, which it is so important to carefully examine, in cases suspected of phthisis. If but one hand is used to percuss with, the fingers receiving the blow must be placed across the

* A paper read at the semi-annual meeting of the New York State Hom. Med. Society, Brooklyn, Sept. 1880.

† Phys. Explor. Chest, p. 78.

* Medical Diagnosis, p. 208.

ribs on one side of the chest, which they lie properly parallel with on the other.

6. Percuss lightly except when bringing out sounds before a class, or when examining the deeper portions of the lung.

Attention to this will help to secure the two things upon which uniformity of percussion note depends, viz., the striking of the same point with the same force at each successive blow. The more forcible the percussion, the less is the hand under control.

It is an axiom in percussion as in carpentry, that it is the moderate blows that hit the nail always squarely on the head. Blows on even slightly different parts of the stroke-receiving finger, will give different qualities of resonance. Strokes varying in force will yield sounds differing more or less in character, while upon the uniformity of the percussion note depends the clearness of perception of its particular character, either absolute or comparative, and therefore its diagnostic value.

7. Percuss with three fingers held together with their ends in line; by following this rule greater ease and uniformity of stroke will be secured.

The centre of gravity of the hammer (the hand) will thus come in line with the centre of the fulcrum (the wrist) and the centre of the striking surface (the end of the middle finger.) This, as well as holding the three fingers closely together gives steadiness to the hand and precision to the stroke.

If there be any one thing which, more than another, is characteristic of unskilled percussion, it is hitting different parts of the finger or pleximeter at successive strokes, and obtaining consequently, a varying and uncertain sound, the value of which is little or nothing.

For very delicate percussion, especially in defining small cavities, etc., the use of the middle or forefinger alone is preferable to three fingers, although not so facile or resonance-giving a method.

Attention to these seven simple rules—a free wrist motion, percussion with the ends of the fingers, even application of the stroke-receiving finger, a rebounding blow, ambidexterity, light or moderately forcible percussion, and the use of three fingers as one—will, with but little practice, render one sufficiently familiar with the manual part of percussion, to intelligently study and make use of, the various sounds brought out.

There seems to be no excuse for anyone at all conversant with the prime importance of percussion in differential diagnosis, in not making an effort to acquire the skill requisite for its intelligent employment. Nevertheless, we cannot forget the fact already mentioned, that skillful percussion is not general, that it is not employed or relied upon, five times in ten, where it ought to be.

What is the remedy for this? Evidently, to diffuse a knowledge of the rules of percussion; but this, by text-books, such as Da Costa on Diagnosis, has already, we may say, been thoroughly done. Is there any other remedy? Does the use of the hammer furnish one? It may have been noticed that no mention has thus far been made of percussion hammers, and for two reasons: first, because *all* American authorities now agree in recommending the fingers,* and secondly for the reason that the form of hammer, which has been in use in this country, is quite inferior to the finger as a means of percussion—a fact apparent to anyone upon hearing the sounds brought out by both means successively, and practically evident to all who have thoroughly learned the proper use of the fingers.

Hospital *internes*, who have large numbers of chest cases to treat, almost invariably forsake the hammer for the fingers soon after their service begins. The idea that a louder sound can be brought out with the hammer than with the fingers is a mistaken one, which the writer, in common with others, long since discarded, after comparison of the results obtained by advocates of the two methods (for the class room) in demonstrations at the Bellevue Hospital amphitheatre.

In the act of percussing, the fingers strike with three points, the hammer with but one; a greater volume of sound, for the same amount of force used, is, necessarily produced by the fingers—a fact easily verified by experiment. The defects of the common form of percussion hammer are, a lack of weight and too great an elasticity in the head of the instrument, whereby uniformity and precision of stroke are rendered fully as difficult to obtain as with the fingers alone.

The sounds produced are higher in pitch than those brought out by the fingers or a heavier headed hammer, which renders the differentiation between dullness (high-pitched) and normal pulmonary resonance less easy. There is also more extraneous sound produced by the contact of the hammer with the pleximeter than by the impact of the fingers upon the cushioned dorsum of the middle digit.

The handle is not well balanced; being quite small and round, instead of broad and flat, it is not so easily nor so firmly held. This defect of shape makes it very liable to turn in the hand and give an oblique and uncertain stroke. The finger will yield better results, costs nothing, and in more senses than one, is much handier than the ordinary hammer. The same remark applies to the use of an artificial pleximeter with even greater force. It is much inferior to the finger as a stroke-receiver, beside its inapplicability to a chest in any degree emaciated, it gives a sound of its own on being struck that tends more or less to obscure the resonance of the lung, while the finger, being both dense and firm enough to transmit the force of the blow and vibrate in unison with the lung, gives no appreciable sound of its own, because of the elasticity of its integuments.

The comparative advantages of the latter are well summed up by Flint* in saying that "the finger as a pleximeter is superior in many respects to any artificial instruments, in size and form, and for application over and between the ribs. The force of application can be easily graduated. The operation is less formidable to patients. It affords information as respects the sense of resistance, which is a point of considerable importance. It costs nothing, and, in the most literal sense, is always on hand. The only disadvantage attending it, is a liability to suffer injury if in constant use"—a thing which in those subject to injury is generally avoidable by using light or moderately forcible percussion.

The pleximeter being larger and wider than the finger necessarily yields a resonance from a larger portion of lung surface, and is thus more likely to overlie and produce resonance from both healthy and diseased tissue. A mixed and confused sound rather than a pure and distinctive resonance is therefore apt to result.

Having detailed the points of inferiority of the artificial pleximeter and of the common form of percussion hammer, the previous question recurs to us. How may we lessen the difficulties of percussion, small as they may really be, so that its intelligent use may become more extended? Is there any method of rendering the act an easier one without sacrificing the value of its results?

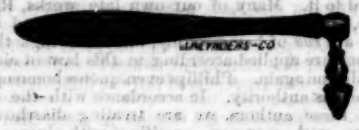
From a repeated trial during the past year of the original form of percussion hammer invented by Winterich, of Germany in 1841, and from a frequent comparison of its results with those obtained by the finger alone, the writer, although previously convinced of the inferiority of instrumental aids to percussor, has been led to believe that it is fully as good, and in some cases better as a percussion than the fingers, while its use is to be acquired with *much greater ease and rapidity* than that of the fingers, by those beginning percussion.

* Profs. Flint and Da Costa, while advocating the use of the hammer on certain occasions, as where many cases are to be examined at one time, agree in recommending the fingers for all ordinary purposes.

* Phys. Explor. Chest., p. 77.

Having a thoroughly scientific construction, it combines an ease and accuracy of manipulation unattainable without constant practice by the other method.

Owing, also, to the greater delicacy of the blows required to bring out a good percussion note, the hammer can generally be used with the fingers as a plexímeter. If the digit be too tender, however, or if many successive



Winterich's Percussion Hammer.

examinations are to be made, a shortened and very narrow pleximeter may be used, and for this purpose the instrument is best made of metal with beveled edges on the under side and covered on the other with a piece of buckskin gummed to the surface.

Before describing the German form of hammer, it may be remarked that it is not held out so much as being a complete substitute for the fingers as an inducement for the practical acquisition of the art of percussion.

But agreeing with all authorities that every one should learn to percuss with his fingers, and that they are entirely sufficient, if may be asked, What is the need of acquiring the use of the hammer; and is it not apt to render one less proficient with either method, if both are to be acquired? Will not the general difference between the sounds obtained by the hammer and those produced by the finger, render one less acutely sensible to slight differences in the normal or abnormal percussion note? In fact, will not one method confuse the other?

At first view, the answer to this question would appear to be affirmative. Practically, we believe that it is not.

The general difference between the percussion notes produced by the finger and those brought out by the hammer, is of the same kind and not as great as that between the sounds produced respectively over thinner and thicker layers of adipose or muscle, a point in which, it is needless to say, chests widely differ. 'Tis not, in any case, the absolute variation of the percussion note from a certain typical standard (if there be any one such standard) by far so much as it is the relative differences between separate portions of the organs examined, which, as a fact, will, at one point or another, furnish their own standard of normality.

In practice, we find the difference in this respect between the hammer and the fingers in no degree embarrassing—a thing we unfortunately cannot say of the great variations in muscle and adipose tissue.

It is also our belief that a knowledge of percussion with the hammer will, from the practical knowledge of the necessary rules thus acquired, lead to the the more frequent acquisition of skillful percussion with the fingers.

We may now pass to the consideration of the Winterich hammer as a mechanism, and its comparison with the hand in this respect.

The fundamental requisites of a good percussor are, a free, short, swinging motion, a large preponderance of weight at the striking extremity, or the closest possible approximation of the centre of gravity to the distal end, and a striking surface, which is both firm and slightly elastic. The instrument of Winterich is a cylindrical iron hammer with a perfectly flat, thin, ebony handle, whose plane is coincident with the axis of the head. A hollow cap screws to the head, and is fitted with a small round piece of vulcanized rubber, of the consistency of an ordinary eraser, flattened on its face, which projects but slightly from the end of the cap.

The instrument may weigh from two to two and a half ounces.

It will be seen that the hammer has a comparatively heavy head and a light handle. This enables one to give a sufficiently forcible blow with but slight effort.

The percussion strokes, therefore, are much more apt to be uniform in force and precise as to point struck, in obedience to the physiological rule, that motions of small force are more easily made regular than powerful ones. Moreover, it is a practical fact that the heavier the head, the more uniform the strokes of the hammer can be made, both as respects the force of the blow and the hitting of one and the same spot.

The lack of a great preponderance of weight at the striking end, or the removed position of the centre of gravity from the distal extremity, is the disadvantage of the hand as a percussor—a disadvantage, however, which can be somewhat overcome by holding the fingers more or less at right angles with the plane of the body of the hand, and thus, at the same time, putting their weight in the striking line and approximating the centre of gravity to that line. But in whatever way the hand is held in percussing, it remains far from being a well-proportioned hammer, and for the reason that so much more effort is required in percussion with the fingers than with a properly constructed hammer.

The lessened amount of effort and skill required to secure precision and uniformity in percussion with the instrument advocated, is its great advantage for general use, while the possibility of finer distinctions between sounds which simulate each other, is its claim to attention on the part of those who are skilled in the use of the finger. Judging from practical experience, it seems to be particularly adapted to light percussion, and the differentiation—especially over small areas—of flatness from dullness, of slight dullness of apex of right lung and of other parts from normal resonance, of indistinct tympanitic or amphoric resonance from normal pulmonary resonance, and of faint vesiculo-tympanitic resonance from dullness, as over the anterior borders of lungs, yielding a percussion note of heightened pitch.

The hammer is superior to the fingers also in forcible percussion, employed to explore deep tissue. The three fingers can certainly bring out more resonance than the hammer, and hence are more valuable for class-room demonstrations, but dividing the force of the blow over three points, they are not as well adapted for developing the resonance of the deep tissue as of the surface of the lung.

The greater suggestiveness of a free, swinging, wrist motion, which the handling of a hammer with heavy head and light flat handle gives, as well as the greater ease of that motion with than without the hammer, tends to fulfill the most important requisite of a good percussor—a naturally acquired use.

The third condition of success—a firm, yet elastic striking surface—is equally possessed by both the finger and the hammer of Winterich. One fault with the ordinary percussion hammer is an excessive elasticity of the rubber head. In the German hammer the shallow piece of rubber at the end of the head, like the skin over the bone at the end of the finger, fully serves to protect the stroke-receiving finger, to quicken the rebound, and to deaden somewhat the sound of the pleximeter, if such be used. A long piece of rubber, such as forms the entire head of the ordinary percussion hammer is far less effective, particularly if the gum be unusually elastic. It will not bring out the sound of which a metallic instrument is capable, even if forcibly employed.

A peculiarity of construction that also contributes to the efficiency of the hammer advocated in this article, is the perfectly flat handle, which aids both the uniformity and precision of the stroke.

Not the least recommendation of a good percussion hammer is the ability to use it in constrained positions, where the fingers, from lack of reach or leeway would be quite useless; as in cases where the patient from pain or weakness is unable to sit up in bed, yet where a physical

examination of the chest is all important. Here the hammer is vastly superior to the hand.

In conclusion, we would say with regard to a subject which may seem hardly deserving of such lengthy consideration, that indispensable as is a perfect knowledge of the characters and values of the various physical signs to be obtained by percussion, its manual or mechanical part is still more indispensible, because it is the only means of becoming practically so familiar with those characters, that their recognition may be depended upon, and their proper value be given them in the physical diagnosis.

OLD SCHOOL VIEW OF ITS OWN WORK.

"HOMŒOPATHY.—WHAT IS IT?"

A Criticism of Dr. Palmer's Book by this name.

By Reader.

A fair critic is one who never allows his prejudices to interfere with his judgment, but judges according to the *facts*, after having carefully weighed the questions at issue.

Dr. Palmer, I am sorry to say, shows too clearly his prejudices against the homœopathic system to be classed in this category. His work is well written, but is simply a mass of theories and deductions, and seems almost barren of *facts*. The science of medicine being an eminently practical science, no theories should be accepted unless proven by *facts, clinical* facts. Dealing, as he does, with the many delicate organs of the human system in states of disease, and the innumerable phases which are presented by the many diseases flesh is heir to, it behooves the physician to search diligently in every direction, and without prejudice, for any information that will assist him to relieve suffering humanity.

It is a generally admitted fact that, for ages back, while great improvements have been made in surgery and all mechanical operations, materia medica and therapeutics have been almost at a stand-still, and exceedingly unsatisfactory. How often does the physician pore over his books in the vain hope of finding *some* help in an intricate case, and close them with disgust! Many an old physician who has seen years of service, and has tried to do his duty conscientiously, will tell you he has lost all faith in medicine. This state of things has turned thousands of physicians towards surgery, for there they find something tangible; they can *see* what the trouble is, and can apply the remedy, and watch its course with much more certainty than in a case of disease.

The medical profession at present, not being satisfied with this state of things, is reaching out in all directions for further light in therapeutics; and all attempts to mislead, or prejudice the mind against the fair and impartial investigation of any new theories, is doing a positive injury to the profession and to humanity; for I contend that *some* good can be gained from *all*, and it is only by *testing* these ideas that we can learn the *truth*.

Having given some attention to the investigation of homœopathy, practically as well as theoretically, I propose to impartially review Dr. Palmer's work.

He begins with some extracts from the life of Hahnemann, which are wholly irrelevant, so I will not waste time upon that subject

The law of similars, which is the therapeutic law of homœopathy, and the pillar upon which that system is founded, Dr. Palmer seems to ridicule, and even deny entirely. Upon what grounds he does this is not apparent, for he does not give any *personal experience*, and I doubt if he had any to give. This law is not new. Many of the old deep thinkers, and those searching after medical information, noticed the peculiar action of drugs upon which this law is founded, and reported it, even as far back as the time of Hippocrates; but none carried their experiments to the extent that Hahnemann did, consequently none put it to use until his time. Now, it certainly is a strange circumstance that so many scientific observers searching for the same thing, improvement in medicine, should have all noticed this same peculiar drug action, if it amounts to nothing. Such a thing seems unreasonable. This law of similars is given as a positive law, and a law of nature. How do we know it is not, unless we test it *fairly* and *practically*? Such arguments as Dr. Palmer brings forward *prove* nothing in regard to it. Many of our own late works, Ringer Phillips, and Bartholow on materia medica and therapeutics, are *full* of homœopathy, and the drugs therein mentioned are applied according to this law of similars time and time again. Phillips even quotes homœopathic physicians as authority. In accordance with the teachings of these authors, we are treating diarrhœa and dysentery with mercury, vomiting with ipecac, sore throat with belladonna, fever with aconite, pneumonia with tartar emetic, and so on.

It is useless to argue that the action of these drugs in these diseases is according to any other principle than the law of similars, for that is merely a supposition. We cannot look inside of a man and see the action of the drug upon the diseased tissue; but when we *know* that these drugs produce in the healthy person symptoms *like* those exhibited in disease, and we are taught that they will relieve the diseases wherein those symptoms are prominent, then there is something tangible, and not half so much guess work—something at least worthy of careful investigation, rather than ridicule.

Dr. Palmer states that homœopaths treat *altogether* by symptoms, ignoring the pathological conditions and everything else. I am surprised that he should expose his ignorance to such an extent. The truth is, their symptomatology and pathology go hand in hand. The symptoms of the case are taken, and the *cause* of those symptoms considered, and a medicine given which will produce in the healthy person symptoms *like* those shown in the disease, and one that has a particular action upon the diseased tissue. Is there anything unscientific in this? By this method *all* the conditions are carefully considered; the symptomatology of course stands first.

Now, as regards the "provings" which Dr. Palmer represents as "pretended," and attempts to ridicule so much, these are made upon *healthy* individuals, male and female, the drug being taken by a number of people differently constituted, and its effects watched. Prof. H. C. Wood, in the preface to his work on Materia Medica, says: "It is the especial province of the therapeutist to find out what are the means at command—what the individual drugs in use do when put into a human system. It is seemingly self-evident that the physiological action of a remedy can never be made out by a study of its use in disease. * * * It is certain that in experiments made with medicaments upon healthy human beings, is the only rational scientific ground-work for the treatment of disease." Prof. Stillé says: "The action of medicines upon the sound organism of man forms an indispensable key to their curative operation in disease." The celebrated Haller said: "In the first place, the remedy is to be tried on the healthy body, without any foreign substance mixed with it; a very small dose is to be taken, and attention is to be directed to every effect produced by it. * * * * You may then pass on to experiment on the body in a state of disease."

Here, then, is a pretty good authority from well-known writers of the regular school for the "proving" of drugs upon the healthy, to learn their therapeutic value. Dr. Palmer ridicules many of the apparently trivial symptoms given in the homœopathic materia medica. Dr. Waring, in his "Practical Therapeutics" says: "Indeed, it should be laid down as a rule in practice that there is no such thing as a trivial symptom; even the smallest in the estimation of the patient, may be fraught with deep importance to the experienced eye of the intelligent practitioner." This is just the ground to be taken in the proving of drugs, that, as the symptoms of a disease,

objective and subjective, however trivial, should be taken into account, so should the symptoms shown by the proving be considered. It may be that in their earnestness to report symptoms, many symptoms have been reported which were not pure drug symptoms, but symptoms peculiar to the prover. In fact I have noticed in many homœopathic journals, articles regarding this fact, and plans proposed for correcting it, by careful systematic reproving—showing that the practitioners in that school know the deficiencies that exist, and are disposed to correct them. Their latest and best works I notice are shorn of much superfluity, a disposition being shown to report *characteristic symptoms* and clinical verifications. This is just what the medical profession want, for we are not so well versed in medical lore that we can afford to ridicule, or discard without thorough investigation, any reasonable practical ideas which will aid us.

Dr. Palmer infers that the homœopaths neglect anatomy, physiology, pathology, and other branches of medical science. In this he is altogether mistaken. If he had taken the pains to visit their leading colleges at Philadelphia, New York, Boston, Cincinnati, Cleveland, or Chicago, he would have seen for himself that as much attention was paid to those branches, also to chemistry, gynæcology, obstetrics, and surgery, as in our own best schools. In fact the *only* difference existing between the two schools is in the materia medica and therapeutics.

Dr. Palmer indulges in considerable ridicule and levity over the "*dose*" question. This has been a great stumbling block in homœopathy. But now let us consider this question rationally and carefully, not from an arithmetical or a chemical standpoint, but from a medical standpoint. We are endeavoring as physicians to cure disease; and to accomplish that result, we administer drugs which we expect will produce such effects upon the diseased tissues as to correct the morbid condition present. It is only the proper *effect* that we are after, and it is not necessary to administer more than will produce that effect. Now, the question is, how much shall we give? and that is also the question in the homœopathic school. There is no positive law upon this question, and never can be, because different constitutions, different types of disease, and the exigencies of a case may require different sized doses, or different strengths of preparation. There is just where the judgment of the physician should show itself. I have found that there is *really* no such thing as a "homœopathic dose;" that their physicians use large as well as small doses; and many of our own physicians use doses equally as small as the homœopaths, but are not homœopaths for all that. Two hundred years ago a favorite prescription contained 60 ingredients; now many single remedies are used, and prescriptions very rarely contain more than 6 or 8 drugs. Fifty years ago many drugs were given in massive doses that are now given in from $\frac{1}{10}$ to $\frac{1}{10}$ of a grain; and better results are gained with much less danger of aggravation. The whole medical profession is gradually coming to the small dose. As to *how* small the dose should be to produce an effect, we will never know until we *try it*. I *know* that I have *seen* remarkable results from *remarkably small doses*.

At a meeting of the New York Medical Journal Association, held in June, 1877, Dr. H. S. Dessan read a paper on "the value of small and frequently repeated doses," giving his experience, which was very favorable. The leading manufacturing chemists are now putting up all manner of drugs in the forms of parvules and granules, about the size of homœopathic pellets, containing from $\frac{1}{100}$ to $\frac{1}{10}$ of a grain of the drug. If there was not a demand for these things, they certainly would not be prepared.

As to the peculiar method of preparing homœopathic medicines, the decimal plan, or one part of tincture to nine of alcohol, is that most generally used. Dr. Palmer alludes to this, but mentions the centesimal plan (1 to 99) as most common. He also says the "30th attenuation is the most appropriate dose of every drug in every disease." This is not so, whether Hahnemann said so or not. Different conditions and different constitutions require different strengths or attenuations, and different sized doses. Homœopaths use all strengths, from the crude drug to the highest attenuation, as the occasion requires. In this matter the physician uses his own judgment, which is just as it should be.

Dr. Palmer seems to think homœopaths are restricted to the use of pellets in administering medicine. In this he is *far* from right. The pellet was introduced simply as a convenient plan of carrying and administering tinctures in a dry form. Very few homœopaths carry them in their cases, using them only in office practice. In their cases the majority prefer tinctures of soluble, and triturations of insoluble drugs. The pellets are medicated by pouring several drops of the tincture over them after the vial is filled; they absorb this tincture just as sugar will do. The medicating by "infection" is not used, as it is impracticable.

As to administering medicines at the bedside, it is most commonly done by mixing several drops (from 6 to 20) in ½ glass of water, giving a teaspoonful at a dose, repeated as often as the severity of the case requires. When giving the pellets, from 4 to 10 are usually given at a dose, according to age, and the condition of the patient. The plan of administering by olfaction has never been and can never become universal.

As to the experience and success of homœopathic treatment, Dr. Palmer would have us believe that all homœopaths are a pack of liars, and will make *any* statements to carry a point. Now, looking calmly at this, how foolish it seems; for many of us are well acquainted with homœopathic physicians who we know would not stoop to a thing of that kind; men of as undoubted honor and veracity as any in the ranks of the regular school. As to the experience of homœopathy, I will simply give some *facts* that I *know*. The report of the two homœopathic physicians in Cincinnati during the cholera epidemic of 1849, that they treated 1,116 cases of genuine cholera, and lost only 35, is *true*, whatever Dr. Palmer may think about it. I also *know* that during that same epidemic, in a certain church in that city, a thorough and impartial investigation was made among its members, and it was found that 165 had had the genuine cholera; 135 had been treated by homœopathic physicians and only *one* died; 30 had been treated by allopathic physicians and 5 had died. I furthermore *know* that during the cholera epidemic of 1872, a homœopathic physician residing in Nashville, Tenn., treated 62 cases of genuine cholera with only *one* death. Now, these death rates are *not* all the same "standing formula," Dr. Palmer to the contrary notwithstanding.

How was it during the yellow fever epidemic of 1878, and in previous epidemics of the same disease as far back as 1853? The homœopaths report a mortality for the whole of only 5.$\frac{1}{10}$ per cent. (6,569 cases treated and 360 deaths.) Can the regular school show as good a report as this? I know there were many who wrote to well-known homœopaths for their treatment, which was given, and their success was only equalled by the homœopaths themselves. When the American Public Health Association met in the fall of 1878, and discussed the yellow fever, why did they not discuss treatment, so *essentially* important a point? Because, as Dr. J. S. Billings himself remarked, no conclusions could be arrived at on that subject, because there was no unanimity upon that point. Almost every man had tried some pet prescription, but there being no rule or law to guide them, they were obliged to vary considerably. I notice that the homœopaths reported treatment, and there was a marked unanimity in their treatment. With a law to guide them, how could it be otherwise? Some will say their reports are not true. We have no reason to believe them untrue, without *proof*.

The success of any institution, particularly one of such a general character as medicine, should not be measured

by its advance in any *one* section of the country. Homœopathy is not quite 100 years old, and yet it has spread to every quarter of the globe. In New York city in 1848, there were only 39 homœopathic physicians; in 1874 there were 210. Philadelphia had 95 in 1867; in 1874 it had 170. Forty-three years ago that system first crossed the Alleghanies. Now Pennsylvania has over 700; Ohio, Indiana, and Illinois, about 400 each; Missouri over 200; Michigan over 350 homœopathic physicians. This state of things would not be, unless there was a demand for this new school of practice; and that demand is not from the lower classes. Go into any of the large cities and towns, and you will find a large proportion of the thinking, reading, and best educated classes adopting the homœopathic practice. In Europe it can be found in nearly all the courts, and used by many of the highest dignitaries. In England, France, Italy, Germany, Russia, Spain, and Belgium, they have schools and hospitals. In America there are eleven homœopathic colleges, and thirty-eight homœopathic hospitals; yet 30 years ago there was only one homœopathic college, and no hospitals.

Now, when we look the matter squarely in the face, and get at the *facts*, does it not seem that a revolution is gradually taking place in the medical profession, in spite of such works as Dr. Palmer's? Here is a medical practice brought before the world less than one hundred years ago, that has gradually spread to every country, where there is any civilization, upon the globe; which is being steadily adopted, not by the ignorant, but by the intelligent classes, in spite of all opposition; and here is the regular school reducing its doses more and more year after year, and in their latest works actually *teaching* the principles of this new system that we have been fighting so hard.

Dr. Palmer's little book is not such evidence as the profession or the people want, or will be satisfied with at this time. *Thorough, practical, impartial* investigation is the only proof, and the sooner we have it, the better for the medical profession and the people.

In conclusion, I would say, homœopathy is *not* small doses, or little pills; but it *is* a system of medicine founded upon a therapeutic law. It does not interfere with any chemical or mechanical department in medicine; it has simply its own special field of action, the treatment of diseased tissues. Anatomy, physiology, chemistry, pathology, surgery, obstetrics, etc., are the same in both schools of medicine. In therapeutics alone do they differ.

If Dr. Palmer had taken the same means to fully acquaint himself with homœopathy *practically*, as well as theoretically, I think he would have reported differently.

In 1840, Dr. H. V. Malan *thoroughly* investigated homœopathy with a view of writing a work against it. Previous to that, Dr. C. Hering, then a student at the University of Leipsic, and a pupil of the celebrated surgeon Rabbi, was commissioned to write a pamphlet against the new system. The difference, however, between them and Dr. Palmer was, that they were determined to prove by actual *facts* the fallacy of homœopathy. The consequence was, that their books were never written; for they became convinced there was more *truth* than fallacy in the law of similars.

Not long since an eminent physician of the regular school remarked to me, that "it was a dangerous thing to carefully and impartially investigate homœopathy." Upon my asking why, he said "he had never known one to do so who did not eventually practice it." That is a great acknowledgment, but when we look at it calmly, is it reasonable to suppose a man will give up his previous experience, and practice a new system, if upon careful investigation he found it false?

The spirit of this age is well shown by "Liberal Practitioner" in the July number of the *Clinic*. Unless Dr. Palmer is careful, the liberal school will leave him far in the rear.—*The Southern Clinic.*

CLINIQUE.

CLINICAL CASES.

By Henry C. Blauvelt, M.D., N. Y. City.

During the past week a man of about thirty years of age, presented himself before the different medical clinics at Vienna, for demonstration. Inspection showed a deep, bowl-shaped depression in the lower portion of the thorax, which at first sight appears to extend to the vertebral column. Close examination reveals the deepest portion of this cavity to be at the point of union of the corpus sterni with the processus xiphoideus, for there is no deficiency of the sternum, simply a backward curve with slight widening of its surface. The ribs are complete; but in their attachment to the sternum follow the curve of the depression. In the vertebral column there is only a slight compensatory posterior curvature, but the thoracic portion is somewhat hyphotic, and bent to the right. The projection of the spinous process of the seventh cervical is not as prominent as usual. Measurements show the diameter of the anterior portion of the thorax from above downwards to be shorter than normal. Depth of the cavity 7.5 centimeters. From the bottom of the cavity to the end of spinous process posterioraly 9.5 centimeters. Allowing for the diameter of the vertebræ, 6.5 centimeters, it leaves 3 centimeters for the distance between the deepest depressed portion of the sternum and the anterior surface of the spinal column.

Examination of the heart shows a visible pulsation in the third, fourth, and fifth intercostal spaces, which extends laterally to the mammary line. In the sixth intercostal space there is no pulsation, but below the margin of the costal cartilages there is a visible pulsation, stronger than that above. Cardiac dullness extends upwards to the under border of the third rib, internally to the median line, inferiorly to the upper border of sixth rib, and towards the center of the depression. Externally not quite to the mammary line.

Dullness of the liver begins on the right of the sternal line at the upper border of the sixth rib; in the mammary line at the seventh; in the axillary at the ninth; by the vertebral column at the twelfth spinous process. Anteriorly, it extends across the depression to the left about two centimeters below the arch of the rib, as far as the seventh rib and the mammary line. The inferior border extends horizontally to the umbilicus, then rises rather abruptly in the left mammary line to the arch of the rib, where its dullness is mingled with that of the spleen, which begins at its normal superior limit and extends to the arch of the ribs, then forwards is blended with dullness of the liver. Between the lower limit of cardiac dullness and the upper limit of hepatic duliness there is a space three or four centimeters broad, which yields pulmonary resonance with a tympanic sound and unclear respiration. In the remainder of the lungs there is a clear uricular breathing. The sounds of the heart are heard in their normal position, clear, with normal force, and but slightly influenced by inspiration or expiration.

Mr. J. W. enjoys perfect health, and, in fact, makes his deformity indirectly support the health of his body, by using it as an easy means of obtaining his living.

He was examined by Professors Henle, Virchow, and other eminent men, years ago, but does not remember their opinion of his case.

If the depression could be forced out, the shape of the thoracic walls would be normal; this points to the probability of an external influence being the cause. Prof. Zuckerkandle, the anatomist, says that in the embyro the head is flexed, and bent so far downwards that the symphysis of the inferior maxillary touches the sternum, and even produces a temporary depression in the soft tissues of the chest. The Professor has in his museum a specimen, in which the symphysis of the in-

ferior maxillary is imprinted in the sternum. Therefore, it is possible that by an abnormal cause the head may be so strongly pressed against the chest as to produce a deep indentation, and the bones being bent in this direction, will not resume their normal shape during later development, but will continue to grow in the direction in which they have been abnormally deviated; this must result in an increase in the size of the cavity, which has actually occurred in this case, according to the patient's own statement.

Although this particular deformity is very rare, I had the opportunity last summer of observing a similar case in Göttingen. In this patient the depression commenced above the second rib, on each side at the mammary line; inferiorly at the sixth rib; below this, the cartilages of the lower rib extended more towards the median line, and arched over the lower portion of the sternum so as to form a deep sulcus.

The depth of the large depression was 9½ centimeters. Posteriorly, the spinous processes were not visible, although the patient was emaciated. There was a slight curve to the right in the lumbar region. The superior border of the liver commenced at the seventh ribs. The apex of the heart was between sixth and seventh rib, two inches to the left of the nipple. A systolic beat was visible at the margin of the depression, below the nipple.

The location of the depression in this patient being nearer to the superior extremity of the sternum—consequently nearer to the symphysis maxillaris—lends additional weight to the theory of Prof. Zuckerkandle; but a theory of equal importance, which cannot be refuted, is rachitis. The first patient had the peculiar power in his arms of being able to place the dorsal surface of his hands on the upper anterior portion of his chest, and at the same time bring both elbows in contact. The second patient, a man of 29 years of age, had talipes vulgus, was much emaciated, and had suffered from attacks of epilepsy since youth. The cause of the latter could not be discovered; but it is probable that one of the many cranial effects of rachitis lies at the bottom of the trouble.

In regard to the thoracic malformation. It is well known that rachitis shows itself most prominently in the chest. By an abnormal exuberant growth of the costal cartilages, the sternum and ribs, especially at the lower portion, are pushed out, forming the so-called chicken-breast—*Pectus carinatum*. Cases have been observed, in which the bending of the lower portion is reversed, or inward. In the second patient I have mentioned, the arching of the costal cartilages over the depressed lower extremity of the sternum, clearly shows the abnormal proliferation of the cartilage; but in this patient the main depression is in the upper portion of the thorax, which is least affected by rachitis—explainable, however, by a union of the two theories; that is, during the intra-uterine life there existed what Winkler calls a fœtal rachitis, and distinguishes from the congenital form by the fact that it has healed at the time of birth. Now, while the sternum was cartilagenous, the pressure of the chin formed the depression of the sternum and the inward inclination of the ribs.

MICROCEPHALOUS.

Lately a female child, eleven years of age, was presented before the medical society of Vienna, and is now on exhibition in the city, whose head is the smallest for its age of any case ever reported. The horizontal circumference measures 33 to 35 centimeters. The forehead is retreating, the vertex pointed, and then suddenly declines in the occiput, as in a head of the kyphus form. The supraorbital ridges are prominent. The eyes are protruded because the skull is short, also the orbital cavity. The lower jaw is imperfectly developed, micrognathus. The root of the nose is small, but the remainder large and prominent, thus giving the face a bird-like appearance. The shape of the cranium is said to be due to the development of the ganglion, while the mass of the hemispheres remains undeveloped. Thus, anterior to the fissure of silvius, the lobes are small, consequently, a flat forehead. Posterior to these are located the large ganglion of the brain, which are well developed, while in the occipital region there is again a deficiency in the size of the lobes. The child's intelligence is so reduced that it cannot articulate any words except papa and mamma. Other pathological symptoms besides the deficiency of intellect are absent. The development of the remainder of the body corresponds to the age of the child. The girl is the offspring of her father's second marriage. Of the seven children from this union, three were normal and four microcephalic. A sister, whose head presented the same appearance, was exhibited before the society in 1870. She suffered from violent chorea, and died at the age of nine years. Dr. Bischof made an autopsy, and published an article concerning the condition of the brain. One of the brothers, four years of age, is perfectly paralyzed. During the pregnancy of the second microcephalic child, the mother remaked: "This baby will also have a small head;" because she suffered from violent repeated attacks of pains in the uterus during the third and fourth months.

CLINICAL CASES.*

By Elias C. Price, M.D., of Baltimore.

Case-Book, Vol. II., page 124. Case, Bursitis or House-Maid's Knee. Remedy, Sticta Pulmonaria.

April 8th, 1880. Mrs. H., aged about 38 years. About two years ago fell on her knee; it has been sore and tender ever since. Some months afterwards it began to swell very gradually; now there is quite a large collection of fluid in the bursa in front of the patella; the bursa is at least one and a half inches in diameter, and projects very nearly as much. Fluctuation on palpation is very distinct. ℞ *Sticta Pulm.*, IX dil., put 10 drops in half a glass of water, and take a teaspoonful every 2 hours during the day and up till bedtime each day. The patient called to see me in ten days or two weeks, improvement very perceptible. ℞ continue remedy. In five weeks it was so near well that she did not think it necessary to take any more medicine. I gave her a two dram vial of the first dilution; she did not use quite all of it

I had some doubt about the medicine being good, both the tincture and the first dilution had thrown down a considerable quantity of black precipitate; having no other I gave this until I could get a fresh supply, but it did the work effectually.

Aug 31. Saw Mrs. H. to-day; the patella is still tender to the touch, there is a scarcely perceptible thickening of the tissues where the swelling was, but not a drop of fluid.

Case, Bursitis. Remedy, Sticta Pulm. Case-Book, Vol. II., page 128, June 20th, 1880.

John Smith, colored man, aged 38, stevedore. (As the name John Smith only occurs 136 times in the Directory, white and colored list, you will be sure to know him when you see him). Has had a large bursa on the front of the right patella for four weeks. If the patient was a woman we would call it house-maid's knee. The knee is quite painful, mostly in the joint; the joint is very stiff, particularly after sitting down for fifteen or twenty minutes, must straighten his leg out, or get up and walk to get relief; has been using liniments, etc., for four weeks, but it still gets worse. ℞ *Sticta Pulm.*, the same preparation and to be taken in the same way as the first case.

June 27 (just one week). Has been at work all last week; has only mixed and taken two portions (20 drops)

* Read before the Maryland Homœopathic Medical Society, Nov. 10th, 1880.

of the medicine. The fluid has all disappeared, though there is a little swelling around the patella and inside the joint. Says he can use the knee as well as ever, has no pain, nor does it get stiff when sitting down. Ordered him to continue the remedy a few days longer.

Aug. 30. Saw his wife to-day. She says her husband's knee remains perfectly well. In all my previous cases the effusion of fluid had been into the knee joint; in a few cases there was also effusion into the knuckle and finger joints.

Perhaps you may not all of you be familiar with the history of my discovery of the peculiar efficacy of this remedy in bursitis, during the stage of effusion. About the year 1869, I was attending a boy 7 or 8 years old, with a very severe attack of rheumatism. It affected his knee, ankle, toes, wrist, and fingers. Gave *Acon.* and *Sulph.* On the second day I discovered a large collection of water in the knee joint; patient no better. Gave *Sticta*, 10 drops 1 to X dil., in half a glass of water, a teaspoonful every hour, intending as soon as the acute symptoms were relieved to give *Sulph.* again, to absorb the fluid. To my surprise, in twenty-four hours the fluid was nearly gone; in twenty-four hours more it was entirely absorbed. For three or four years I had frequent opportunities of using it, and in acute cases always with success. Scrofulous patients require the intercurrent use of *Sulph.* In chronic cases of long standing it is perfectly useless.

Strange to say, for several years I have seldom seen a case requiring its use.

I published my observations in the *American Observer*, Vol. X., 1872, page 162. Some years afterwards Dr. E. Hasbrouck, of Brooklyn, N. Y., had some cases that proved very obstinate. Remembering my article in the *Observer*, he hunted it up, gave the remedy, and cured the patients with surprising rapidity. It appears that Dr H., like myself, about that time had a succession of cases, and finding the remedy so effectual became perfectly enthusiastic about it. He called Prof. Helmuth's attention to it, wrote to Dr. Massey, of England, in reference to it (the article was published in the *Homœopathic World*, an English journal), and wrote to me for my further experience with the remedy. A portion of my letter in answer to him was published in the Transactions of the Homœopathic Medical Society, of the State of New York. On several occasions Dr. H. has called attention to it in the *U. S. Med. Investigator*.

A further endorsement of it in this disease will be found in Hering's "Condensed Materia Medica," in Lilienthal's "Therapeutics" and Hughes' "Therapeutics," and the 3d Edition of Helmuth's "Surgery."

In one of my letters to Dr. Hasbrouck I recommended a trial of it in Hydropericardium resulting from rheumatic carditis, in pleuritic effusions, and in Glaucoma. I have had but one opportunity of trying it in pleuritic effusion since then, and then I made the mistake of not using it until the patient had had the disease fifteen days, and, the patient being about 70 years old, the disease had assumed a chronic form, and the remedy did no good. *Sulph.* for three or four weeks removed the effusion, and *Lyc.* 30 for some remaining symptoms effected a cure.

In rheumatic inflammation of the synovial membranes lining the joints, either before or directly after the effusion has taken place, I believe it is decidedly the best remedy we possess. I suppose I have treated over twenty cases with it, and know whereof I speak.

STRONGYLUS GIGAS.—M. Megnin (*Le Prog. Med.*, presented to the Biological Society, a female specimen of this parasite which measured 80 cms. in length, and 1 cm. in breadth. The specimen had been found in a bitch suffering from a mammary tumor near the umbilicus. Ordinarily these parasites are found in the urinary organs of dogs. M. Grehant had found one in the peritoneal cavity of a dog. (T. M. S.)

CLINICAL OBSERVATIONS BY DR. JOUSSET.*

CHRONIC ENDOCARDITIS—MITRAL INSUFFICIENCY THE RESULT OF ACUTE RHEUMATISM. INFUSION OF DIGITALIS.

M. X., a gardener, 84 years of age. Until last year this man had enjoyed good health and was of a vigorous constitution. At this date he had an attack of articular rheumatism, which lasted for six weeks. At the end of this time he returned to work but discovered that he became easily fatigued. He suffered also from palpitation and dyspnœa. He had not been able to do any work for several weeks.

Dec. 8. On his entrance into the hospital, there was a marked congestion of the face, his lips were of a purple color, and the respiration was difficult especially during the night. He complained also of pain in the epigastric region. The pulse was feeble, irregular, non-synchronous with the heart; for while the pulse was at 60–66 pulsations per minute, the heart was beating at 100–108 pulsations. The heart was increased in volume. A blowing sound was heard at the apex, and also during the first sound. There was no œdema. *Spigelia*[1] was given, and later, for the increasing dyspnœa, *Cactus*.[1] Dec. 13. No better. *Digitalis*, ten drops, was given. This medicine was continued till the 19th, when the dose was increased to fifteen drops. The patient felt in the first two days, a relief during the day, but he suffered very much during the night. An injection of 0. 01 c. of *morphine* was given each evening, which relieved the dyspnœa and gave a tranquil night. From the 19th to the 24th he took *Arsenicum*, but without any relief. Beginning with the 24th he took each day 0.15c. of the powdered leaves of *Digitalis* in 200 gr. of water. On the 30th there was a marked improvement. The dyspnœa was lighter and the face less congested. The injection of morphine had not been used for several days. *Digitalis* in infusion was continued. Jan. 2. The patient was discharged. The pulse and the heart were synchronous. The improvement still continued many months afterwards. *Spigelia*, *Cactus*, *Digitalis* failed almost completely in this case of a marked pathological condition, and it was not till the infusion of *Digitalis* was given that relief was obtained. One week was necessary to produce a decisive and lasting effect.

I desire, also, to call attention to the favorable result following the hypodermic injections of morphine in cardiac dyspnœa. This anti-dyspnœa action of morphine and of opium has been clearly shown in Hahnemann's pathogenesis of the drug. But the physicians of the old school have been the first to apply the injections of morphine to the treatment of dyspnœa.

CHRONIC NON-RHEUMATIC ENDOCARDITIS—MITRAL INSUFFICIENCY, CARDIAC CACHEXIA.

A. C., age 64 years, entered the hospital Jan. 9. He had never had rheumatism. For some years he had had frequent attacks of bronchitis, each one of which lasted for some time. About six months ago, he had palpitation of the heart for the first time, and this was followed by œdema of the lower extremities. He had been confined to the bed for the last three weeks. On entering the hospital the patient complained of intense dyspnœa and palpitations. There was considerable œdema of the lower extremities, scrotum and abdominal walls, with a less degree of œdema in the superior members. There was also ulceration of the lower extremities. The face was congested, respiration short and difficult. On auscultation numerous subcrepitant, sibilant, disseminated, bronchial râles could be detected. The expectoration was copious and was composed of yellowish or pearl-white sputa. The heart was not, apparently, increased in volume. At the base the sounds were dull and irregular, but there was no murmur. A murmur was heard at the apex during the first sound, with its greatest intensity, not at the apex, but

* Translated from L'Art Medical, August, 1869.

near the scrobiculus cordis. The pulse was small and slightly irregular. The urine was of a deep color and lessened in quantity. Several remedies were prescribed without any marked relief, and on the 15th the expectoration was freer and the œdema increased. *Digitalis* in the first decimal trit. of the leaves was given, and continued for several days. On the 21st, the urine was clearer and more abundant, the œdema less and the respirations better. On account of the prominence of the pulmonary symptoms, *Phosp.*[6] was given in alternation with the *Digitalis*. The urine was sufficient in quantity, and the œdema of the upper extremities had lessened. On the 26th the dyspnœa was increased and the urine of high color, so that *Tartar emet.*[1] was again prescribed. This remedy was continued until Feb. 1st, when the amelioration was marked. Feb. 4. For the last day or two the urine had diminished, and *Digitalis* was given and continued until the 10th. At this latter date the patient desired to leave the hospital. The respiration was easier, and the expectoration diminished. The œdema had disappeared from the arms and the abdomen, but still remained in the legs. The soft murmur was still present, having its maximum intensity in the epigastric region. The cardiac murmur had not been detected for the first few days in consequence of the bronchial râles. For this reason the treatment was begun with the *Arsenite of antimony;* the general condition indicating a disease of the heart without a murmur, we had thought of chronic aortitis.

On the 4th day under the use of *Digitalis*, in the dose of 0.25c. of the first dec., the urinary secretion became clearer and more abundant when the dose was increased to 0.50c. or 0.60c. After ten days' treatment the œdema had also materially diminished and the action of the *Digitalis* upon the urine continued after its suspension, notwithstanding the intervention of *Tartar emet.*, until Feb. 6th., that is for eleven days. At this date we returned to *Digitalis* with an increase of the dose to 0.75c. The amelioration was considerable. The patient left the hospital feeling very much benefited. We have learned since that he died some weeks later from this cardiac affection.

The endocarditis had succeeded, or rather had supervened, as a complication of chronic catarrh; the patient had never had acute articular rheumatism. The coincidence of articular rheumatism and endocarditis has an important clinical bearing, and it has given rise to a certain fascination for pathologists who have not always given sufficient attention to cases of non-rheumatic endocarditis.

CHRONIC NON-RHEUMATIC ENDOCARDITIS—MITRAL INSUFFICIENCY.

Le Bl., a tanner, age 54 years, entered the hospital Dec. 30th. His health had always been good until last August, and he had never had rheumatism. At the above date he began to have palpitation of the heart and a cough. He however, continued at work until near the end of Nov., when the above symptoms were very much aggravated. When he entered the hospital complained of intense dyspnœa and œdema of the legs, which had appeared three days before. The pulse was small, slow, regular. The heart was not increased in volume. There was a low systolic murmur having its maximum at the apex. No dullness of the chest on percussion, but on auscultation numerous bronchial râles, scattered through both lungs, could be detected. Jan. 3. On account of the pulmonary congestion, *Bry.*[6] and *Phosph.*[6] were given. Jan. 5. The pulmonary symptoms were ameliorated and *Digital.*[6] was given. Jan. 7. The urine continuing scanty and the œdema of the lower extremities not diminishing, *Digitalis*, first trit. 0.25c. was given and increased on the night to 0.50c., which was continued until the 20th. Under the influence of this remedy the patient passed each day from a litre and a half to two litres of urine, and the œdema diminished. The medicine was suspended on the 20th. Jan. 23. Patient complained of constrictive pains across the chest, principally at the attachments of the diaphragm, the pains resembled cramps. For this condition *Cuprum*[3] was given, which relieved the pain. The former symptoms returned and *Digitalis*[1] 0.25c was given with the same result as before. Feb. 5. The remedy was given in the thirtieth. The pulse became stronger, the œdema and dyspnœa disappeared and the strength returned. The patient left the hospital on the 17th of Feb., very much improved but still showing the physical signs of mitral insufficiency. Here was a case of chronic endocarditis without any antecedent rheumatism. *Digitalis* in the 6th dilution did not produce any effect, while the first decimal trit. of the leaves produced after an interval of three days a notable change in the urine and increased the force of the pulse. This improvement in the pulse continued for many months, as demonstrated by the spyhgmograph. Had the 30th dil. any action in the continuance of the amelioration? This cannot as yet be affirmed.

CHRONIC RHEUMATIC ENDOCARDITIS—MITRAL INSUFFICIENCY, ŒDEMA, ASCITES.

C., a butcher, age 48 years, was admitted to the hospital Jan. 28. This man, who was of a vigorous constitution and of good general health, had about fifteen years ago, an attack of articular rheumatism. Although the rheumatism had not returned since that time, yet he often suffered from palpitation of the heart. For the last four months the least effort brings on dyspnœa and increased palpitation Jan. 30. There is œdema of the lower extremities and considerable ascites. The dropsy began about fifteen days before. The face was deeply congested. The pulse was small, irregular, slow; the tracings showing the usual markings of the pulse of mitral insufficiency. Percussion of the heart showed that it was partly covered by lung tissue. On auscultation we found the first sound loud and accentuated, but no marked murmur. The urine was scanty and turbid. *Digitalis* first dec. trit. was given in doses of 0.25c.; afterwards of 0.50c. The latter dose was continued until Feb. 9. The urine became clearer and increased in quantity, until it reached two litres a day. After eight days of this medication the œdema of the legs was nearly as great as before, but the ascites had notably diminished. Feb. 10. The dose of the medicine was increased to 0.75c. On the the 13th medicine was suspended. The amelioration of the symptoms was marked. The patient sat up all day and there was only a slight œdema about the malleoli. The urine was profuse; the ascites entirely gone. On the 17th the patient left the hospital very much improved. The patient took a litre of milk a day, and drank some beer at mealtime.

In this case the endocarditis was of long standing, as the patient had always suffered from palpitations since the attack of rheumatism, fifteen years before; but it was only within four months that his condition became aggravated and the disease began to advance rapidly towards a cachexia. Notwithstanding the long duration of the endocarditis, we have never been able to detect a true murmur. But the characteristics of the pulse, the dyspnœa and the dropsy did not allow of any hesitation in the diagnosis. We have already in our Practical Medicine noted and explained the absence of the murmur in the lesions of the mitral valve. The dropsy assumed, in this patient, a rare form for disease of the heart. The ascites was considerable and the œdema of the legs was relatively much less.

The action of the *Digitalis* was as prompt and as complete as in the preceding cases. I often see this patient and he continues well, the dropsy has not returned, (may), nevertheless he takes from time to time a dose of *Digitalis*.

CHRONIC NON—RHEUMATIC ENDOCARDITIS. AORTIC INSUFFICIENCY. Temporary amelioration from the *Arsenite of Antimony* and *Digitalis*. Sudden death.

C. H., stone-cutter, age 52 years, was admitted Dec. 29, 1879. This patient had always possessed good health

and had never had rheumatism. It was only a month since this man gave up his work, as it was only within that time that he began to suffer from palpitations and dyspnœa, the latter especially in the night. There was slight œdema in the lower extremities, which had first appeared four days before. Percussion showed the heart to be increased in volume. On auscultation an intense murmur could be heard at the base and during the second beat; this murmur extended to the apex of the heart. The pulse was strong, regular, and frequent. The sphygmograph showed an ascending perpendicular line, a marked level one, and an oblique descending line without any undulations. With the stethoscope we could detect the double crural murmur. We gave the 2nd trit. of the *Arsenite of Antimony* in doses of 0.20c. Jan 3. The amelioration was noticeable; the respiration was easier. The medicine was continued until Jan. 10th. Jan 12. The pulse which had until now been only of moderate frequency became very much quickened (over 100 pulsations), the respiration was difficult, the œdema increased in the lower extremeties; at the same time the murmur became more intense at the base. The sphygmograph gave a line of ascension much more brusque and higher, with a small hook termination; the double crural murmur had disappeared. He complained of pains in the epigastric regions, and had bilious vomitings. *Aconite*[1] was given, and continued until the 16th. At this date the frequency of the pulse was less, but the dyspnœa was severe; restlessness at night. *Cactus*[1] gtts. x was prescribed. From the 18th to the 24th we gave *Nux vom.*, 3d and 6th, for the marked gastric symptoms. There was a loss of appetite and a desire to vomit. The *Nux* controlled those symptoms. Jan. 24. The urine had been scanty for several days. The œdema was increased in the lower limbs, and had reached the abdomen. The condition of the heart was apparently the same. The murmur, though always present, existed in a variable degree. It was the same with the crural murmur, which on certain days disappeared completely. The pulse was strong but slow. *Digitalis* first trit., 0.25c. was given, and on the next day increased to 0.50c. This remedy and dose was continued till Feb. 6th, when there was marked amelioration, and the urine was increased in quantity within seven days after the commencement of the *Digitalis*. At the same time the intensity of the cardiac murmur diminished and the crural murmur returned. For the fever, which recurred on Feb. 6 and 7, *Aconite* was given. On Feb. 10 the *Digitalis* 1 was again given in doses of 0. 50c., and increased to 0.75c. This medicine was continued till the end of the month, except for three days, when *Lycopod.* [30] was given. Notwithstanding the use of *Digitalis*, *Arsenicum*, and *Puls.*, the patient grew worse, and died suddenly on the 23d of March.

This case is also an example of non-rheumatic endocarditis; the progress being sub-acute and only of about four months' duration, terminating suddenly in death—as often happens when the seat of the lesion is in the aorta, or at the aortic orifice. You will notice that the treatment of the case differed from that of the preceding cases, which were lesions of the mitral valves; and that *Digitalis*, prescribed at a time when the symptoms closely indicated it, produced only a very transient, palliative effect. We would call your attention to the unexplained fact of the disappearance of the second murmur during the period of aggravation. On the entrance of this patient into the hospital, we noticed very distinctly along the crural (?) artery a double murmur, corresponding with the insufficiency of the aortic valves. The first sound was increased, and corresponded to the cardiac systole and the arterial diastole, and was heard when applying lightly the stethoscope upon the track of the artery; the second sound was weaker but clear, and corresponded to the cardiac diastole and the arterial systole, and was only perceived under strong pressure of the stethoscope; it was this second sound which disappeared during the attack of fever, and which was again very noticeable when the pulse lowered under the influence of *Digitalis*.

The theory that this second arterial sound is but an echo of the diastolic murmur which exists at the base of the heart in every case of aortic insufficiency, is disproved by this observation. In fact, this second arterial murmur disappeared in our patient during the aggravation of the endocarditis, and at a time when the cardiac murmur was stronger than ever.

Does the theory that the second sound is produced by the retrocession of the blood in every arterial branch during the diastole of the heart, explains clearly the disappearance of the second sound in this case? Certainly not; but we may ask if the aggravation in the endocarditis was not accompanied with a certain degree of aortic narrowing? In such a case it would be easy to understand the disappearance of the second arterial sound, since the second sound does not exist in narrowing of the aortic orifice. (T. M. S.)

TRANSLATIONS FROM GERMAN JOURNALS.

F. G. OEHME, M. D., TOMPKINSVILLE, STATEN ISLAND.

SODIUM IN HYPERTROPHIA CORDIS DILATORIA.—A boy of 10 years, somewhat scrofulous, blond hair, light complexion, blue eyes, ruddy looking, with phlegmatic-sanguinic temperament, hearty eater, was taken 3 years ago with long continued, severe palpitation of the heart after a hard run. Since then the attacks have appeared always after vigorous exercise, but not as violent, with the exception of the last, which was attended by asthma. Even while he is at rest, the breathing is accelerated and seems somewhat laborious; a pulsating motion of the clothes covering the chest is very noticeable, but the strong action of the heart is still more perceptible when the chest is uncovered. The force of the radial pulse is not proportional to the violent action of the heart; it is comparatively weak, but of the same rhythming. At times fullness, heaviness and oppression in the chest. The face is bloated and the neck thick. Violent motion produces at once severe palpitation, which is mitigated best by application of cold water compresses. Appetite good, but occasional vomiting. Dull sound of percussion over a larger space than normal size of the heart. In auscultating, the ear feels as if it was pushed off by the intense beating of the heart in the region of the fifth and sixth rib. On account of the thinness of the valves one hears a sound as if from metallic wires; all other sounds are lost in the violent pounding of the heart, which shakes the whole chest and is heard equally strong in front and back, right and left, up and down. The sounds seem clear. The disease is Hypertrophy of the whole heart and enlargement of its cavities, which has been developing for some time and may have commenced soon after having scarlet fever five years since. As the boy was of a sluggish temperament and averse to exercise, the disease would develop without being noticed as readily as in a very active child. Coffee, beer, and wine were forbidden and a light diet recommended. *Acon.*, *Bellad.*, *Spigel.*, *Pulsat.*, and *Natr. mur.* ineffectual. Attacks of palpitation appear spontaneously; the slightest motion, as turning in the bed, and trifling affections of the mind provoke them. *Sod.* 3., every day one dose. Decided improvement after a week; continued, steady improvement and after six months almost complete cure. The following six months removed the last vestige.—*Hirsh. Jaschr. f. Hom. Klinik* 27. 92. *Heyberger.*

INDUCED TUBERCULIZATION.—M. Hippolyte Martin injected finely triturated powders of *Lycopodium* and other similar substances into the peritoneum of rabbits, and the resulting lesions were in every case identical with tuberculous lesions. (*Le Prog. Med.*)

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"*A regular medical education furnishes the only presumptive evidence of professional abilities and acquirements, and* OUGHT *to be the* ONLY ACKNOWLEDGED RIGHT *of an individual to the exercise and honors of his profession.*"—Code of Medical Ethics, Amer. Med. Ass., Art. IV., Sec. 1.

MEDICAL HYPOCRISY.

The man who in his teachings marks out a law from which there is to be no departure and himself disregards that law in his daily practice, is a medical hypocrite. The brave man stands boldly before his colleagues, with nothing to conceal. He is not afraid of discussing the great theories of the day, not in the spirit of one who believes that the *Ultima Thule* of all science has been reached and that there is nothing more to be learned, but in that broader spirit which looks upon science as progressive. It is not always easy to be honest, but it is always contemptible to be a coward; and that man is the meanest of all cowards, be he either theologian or physician, who places himself in any position where he cannot act in accordance with an enlightened judgment, or, so acting, is afraid to show it openly. Practice what you teach and teach what you practice, giving a reason for your work, but no apology and no excuse. The public soon learn to respect such men because they can always believe in their honesty and sincerity. The profession is full of hypocrites and cowards, —men who dare not speak out what they think; who dare not act according to the instincts of gentlemen, lest they offend professional bigots, who will turn against them some weapon from a wonderful code of ethics or dethrone them from their position as professional leaders.

In a profession claiming to be learned, scientific, and composed of gentlemen, there is more actual cowardice, more contemptible meanness and hypocrisy in the medical profession than in any other—always excepting the theological. We do not say there are no noble men in both, for both are full of the brightest examples of noble, honest, God-fearing men, whose self denying work and bright example should bring a blush of shame to the miserable time-server whose god is his pocket and whose life is centered in self. If there were fewer faint hearts in our profession, a little more honesty, a little less hypocrisy and cowardice, and a great deal more rising above every selfish consideration in our studies and in our professional labors, what tremendous strides humanity in its highest and noblest attributes would make in its great work of regeneration!

STATE SOCIETY.

The Annual meeting of the State Society will take place in Albany, Feb. 8th and 9th next, and we hope there will be a full attendance of members from all parts, and an interesting session.

The meetings would prove much more useful, if discussion could be elicited, and the way to do this is for the authors to reduce their papers to the practical points which they wish to make, and thus bring them practically before the Society. In long Essays the salient points which should be discussed are frequently lost to the listener, from extended elaboration, and the resumé becomes a matter of great importance! Sufficient time should be given to this most important part, and it is often within the power of the presiding officer, if the author fails, to suggest the theme for discussion which should have been made to appear by the essayist. There has been a tendency to allow papers to drop dead, for want of proper handling, and this is the change which we would like to see accomplished at the forthcoming meeting.

The general feeling is, that the Society does not occupy that position which its importance as a representative organization entitles it. This condition is due largely to two factors: first, the lack of suitable organized effort; and second, inertia of its members.

The first ought to be overcome by the action of chairmen of bureaux, and the second would also be influenced by this, together with such executive management as could be brought to bear.

This Society ought to be ever on the alert to grasp those issues which are constantly agitating the public mind, regarding questions of health.

There should be more effort to interest its members in work, which should be methodically laid out and systematically prosecuted.

Some of our ablest workers can only be induced to lend their aid by the suggestion of a subject by another, and valuable service can be obtained if chairmen of bureaux will devote more time to correspondence.

We want to see the Society continue second to none in usefulness and influence, and we shall hope to see renewed effort in this direction by bringing a larger number of helpers into the field through some means.

HEALTH AND PROSPERITY.

If all classes of people could only be brought fully to understand that much of prosperity depends upon the public health and that violations of sanitary laws are not confined to the tenement houses and the poor, but are almost equally flagrant among the rich and those who, from their superior intelligence, should know better, the list of disease and death would be immensely decreased, and we should build up a prosperity on a sure and enduring foundation.

The reason why the death rate of New York, with its superior natural advantages for health, is so much greater than many of the large cities in the north of Europe, is due to the fact that here there are deficient municipal regulations. This excess in our death-rate

could be prevented by proper municipal laws, and thus thousands of useful lives saved to the community, and thousands of dollars which now flow in a continued stream into the great purse of charity could be used for home comforts and public improvements. It is estimated that in 1871–72 the pecuniary loss in Philadelphia alone from small-pox, which could have been prevented, was at least $20,000,000, and who can estimate the loss in money and lives in the cities and villages of the nation during the present year from diphtheria, scarlet fever, typhoid fever, pneumonia, and many other diseases, much of which may have been prevented by proper municipal regulations? Our city is entering upon a new administration and if our officials wish to make a name in history higher than mere politicians looking for public spoils and increase their lease of power to an almost indefinite extent, they have only to enforce such municipal regulations among the rich and poor as will make this city what it is capable of being made, the healthiest in the world. If the city lacks the power, the State will willingly give it for the asking.

JAMAICA DOGWOOD.

Dr. Ott publishes in the *Archives of Medicine* some interesting experiments he has made with the fluid extract and active principle of this drug, upon rabbits and frogs. The experiments show that the active principle and the fluid extract produce like results. The drug increases the respiration, produces incoördination, blunted sensibility, slowness of the heart, contraction of pupils, followed by dilatation, convulsions, asphyxia and death. It does not paralyze or excite the motor nerves and it does not act on the extremities of the sensatory nerves but their central connection—the sensory ganglia of the spinal cord. It produces convulsions, partly by stimulation of the spinal cord and partly by lengthened excitability of the voluntary striated muscles. It produced the frequency of the pulse by an action on the heart itself, probably on its muscular structure. The arterial tension temporarily rises by stimulation of the monarchial vaso motor centre and soon falls, which is due to a partial paralysis of this centre and the heart itself.

The experiments are interesting and confirm the partial provings which some of our friends have made of the drug.

BERGH ON THE RAMPAGE.

The following is the text of a proposed law:

AN ACT to prohibit the Vivisection of Animals.

The people of the State of New York represented in Senate and Assembly do enact as follows:—

SEC. 1.—Every person who shall perform or cause to be performed or assist in performing in or upon any living animal an act of vivisection shall be guilty of a misdemeanor.

SEC. 2.—The term "vivisection" used in this act shall include every investigation, experiment or demonstration producing or of a nature to produce pain or disease in any living animal, including the cutting, wounding or poisoning thereof, except when the same is for the purpose of curing or alleviating some physical suffering or disease in such living animal, or in order to deprive it of life when incurable.

SEC. 3.—This act to take effect immediately.

Like most special legislation this proposition is altogether too broad to be allowed to pass, and we trust that our legislators will have the good sense to defeat it. No one regrets more than we do the infliction of pain, but there are circumstances under which it is absolutely necessary, and its decision can safely be trusted to the conscientious physician.

In the interest of humanity we protest against this interference with physiological experiment, which has done so much to place the practice of medicine on a scientific basis. Mr. Bergh is mistaken in supposing that his statute will put a stop to vivisection—it will only make it less public.

HOW OTHERS SEE US.

The subjoined letter indicates the impression made upon our "Old School" colleagues of some of our so-called clinical experience. There is more truth in it than we could wish.

URBANA, O., *Jan.* 21, 1881.

MESSRS. EDITORS:—

You will please to discontinue my HOMŒOPATHIC TIMES. I have read it carefully for the past year, and there is a tendency in the contributions which I do not like, and that is the worship of Hahnemann; the religious papers do not have so much to say about our infallible Saviour as many of your writers have to say about that man. I cannot see the object of trying to prove that he was right in every particular, in preference to maturing your law, and correcting your laws to conform to the advancement of science, rather than trying to dam up the flow of wisdom and square it by Hahnemann before you let the people have it. And when I read of Hughes, one of your great lights, discovering errors in Hahnemann's provings and leaving them unchanged, "out of reverence for the father of medicine," I was simply disgusted, and said to myself, these men are not to be trusted with the health of any community; and further, when I read of four minute doses of sulphur, given in four consecutive months, to cure an acute disease which is self limited, and the result, a cure, given to your readers as a basis for their practice, I must say that the history of disease is not known by you. You may say that we have such writers in our school; we have, but their writings are not given to the public without a criticism. I am,

Very Truly Yours,

P. R. BENNETT, M.D.

STATE CHARITY.

The State Board of Charities has made an elaborate report to the Legislature, and it states that the hospitals for the acute insane, in the order of their organization, are the New York State Lunatic Asylum at Utica the Hudson River State Hospital at Poughkeepsie, the State Homœopathic Asylum at Middletown, and the Buffalo State Asylum for the Insane at Buffalo. The New York State Lunatic Asylum is fully completed, and has capacity for 600 patients. The buildings of the other institutions are so far advanced as to furnish room for about 200 patients each The State Homœopathic Asylum is being extended, and the buildings are nearly completed. The Buffalo State Asylum has been open only a few months. Each of these new hospitals, when finished in accordance with its original design, will furnish room for 400 patients. It will thus be seen that the State at present has accommodations for 1,200 acute insane, and upon completion of these projected hospitals its accommodations will be adequate to 1,800 patients. The number of insane under treatment and care in these hospitals October 1, 1880, was 1,044, as against 1,033 October 1, 1879.

On October 1, 1880, Willard Asylum sheltered 1,619 patients, as against 1,493 the year previous. In various county asylums of the State there are 1,234 patients. The authorities of most of these counties have refrained from erecting buildings adapted to their needs, expecting that the State would enlarge its accommodations so as to meet their requirements. Some of the more violent and distressed insane have, from time to time, been transferred from these counties to the Willard Asylum, yet many of them are still burdened with considerable numbers of disturbed and troublesome cases, for whose care no adequate provision exists. If the State, therefore, does not extend its accommodations so as to receive and provide for the chronic insane of these counties, the county authorities will, of necessity, soon be compelled to make provision for them. While it is probably true that a small portion of the chronic insane may be cared for in connection with the county poorhouses, the mass require a supervision and oversight which cannot be extended to them in association with other paupers. Hence, the erection of buildings adapted to the condition and needs of this class becomes a public necessity. When these buildings are erected in connection with the county poorhouses, and are, as is usual in such cases, under the same supervision, the standard of care for the insane varies according to the individual views of the officers in charge, instead of being based upon and adapted to the real needs of this class. If the keeper be a person of kind and humane sympathies, he spares no effort to provide a suitable diet, proper attendants, and every needed facility for the comfort and welfare of the insane. The kindly interest shown by him toward this class extends also to the paupers in the poorhouse; and, as a result, the standard of care for them is raised beyond their actual requirements. The whole establishment, in consequence, becomes expensive and burdensome, and soon excites criticism and distrust in the community on the part of those taxed for its support. On the contrary, if the keeper, as is not unfrequently the case, be governed by motives of economy only, the standard of diet and care for the insane is lowered to that fixed for the poorhouse inmates, and is, therefore, wholly inadequate to its purposes. The insane, as a consequence, soon become impoverished, violent, filthy, and disturbed, and the efforts at economy, in the end, lead to increased and expensive burdens. Moreover, in the frequent change of keepers occurring in counties thus providing for their chronic insane, great abuses imperceptibly creep into the management, which result in irreparable injury to the insane, and become a matter of deep regret and mortification to its citizens. For these reasons the Board, in authorizing counties to retain their chronic insane, has invariably advised the erection of separate buildings, and the placing of the insane, whenever practicable, under management apart from the poorhouse. In counties where the number of insane under care reaches 100, the employment of a resident physician is required by the rules of this Board. From an extended and careful examination of the subject in all its varied aspects, the Board early reached the conclusion that the proper care of the chronic pauper insane could be better and more economically secured in institutions controlled and managed by the State, than in institutions under the management and control of counties.

The institutions for the blind are the New York Institution for the Blind in New York City, and the New York State Institution for the Blind, at Batavia. The New York institution receives its pupils from the city of New York and the counties of Long Island, and the New York State institution from all of the other counties of the State. The former had an average of 206, and the latter 191 pupils, for the year ending October 1, 1880. The average number of pupils under instruction in them for the year ending October 1, 1879, was, respectively, 207 and 168. One of the most difficult problems in dealing with blind children is so to educate them that in after life they may become self-supporting. These institutions employ skilled teachers in music, mechanics, etc., for the instruction of their pupils, and many of them exhibit great proficiency in their pursuits. When the pupils go out of the institution, and the discipline and training of the teachers are no longer felt, the tendency is, under repeated discouragements, to relax their efforts at self-maintenance in the direction in which they had been instructed, and to take up new and often precarious pursuits; and they are thus liable to become dependent. The failure of many of this class may be attributed to a want of tenacity of purpose to adhere firmly to the calling or pursuit to which they were specially educated.

BIBLIOGRAPHICAL.

THE HOMŒOPATHIC PHYSICIANS AND SURGEONS OF AMERICA. Edited by Henry N. Guernsey, M.D., etc., etc., and Joseph C. Guernsey, M.D., etc., Philadelphia: Chas. Robson & Co.

The publishers announce that the book will be "royal octavo, of not less than 600 double-column pp., in brevier, illustrated with engravings on steel, and issued at a low price. Ready about October, 1881."

If this work is confined to biographical statistics it will be of great value for reference. We trust the *buncombe* with which a similar work, issued some years ago, was laden will be avoided. We do not approve of the proposition to mix up "methods of treatment," etc., many of which are not worth repeating! But who has *the right* to discriminate? Certainly not the editors under such circumstances.

Biographical sketches of the living are in bad taste, and misleading, excepting in the case of those who have really contributed something extraordinary to the fund of professional knowledge.

It will be much better to let each one rest on the foundation he has laid by his own efforts, be it firm or otherwise; and the only way to do this is to state plainly and without comment just what that is. What will the readers care for the estimation in which one holds himself? Neither will they be satisfied with that of any other, as it will be either too high or too low to suit. Consequently, we say let all this alone, and your ungarnished *facts* will be of great service to many.

TEETHING AND CROUP. By W. V. Drury, M.D., M.R.I.A., Physician in charge of diseases of children to the London Hom. Hospital, etc., enriched with notes and additions by T. C. Duncan M. D., Pres't American Pædological Society, etc., Chicago, Duncan Bros. 1881, pp. 58.

A vast amount of information of great service to the layman, together with concise therapeutic indications.

THE HOMŒOPATHIC COURIER. Editors, Drs. J. T. Boyd, J. T. Kent, Wm. C. Richardson and J. W. Thrasher, each occupying Professorships in the Homœopathic Medical College of Missouri. Monthly, 64 pp.

The Salutatory claims that "homœopathy in the Southwest has never had a representative Journal," for which our friend Valentine is to be commiserated.

THE HOMŒOPATHIC PHYSICIAN.—A Monthly Journal of Medical Science, E. J. Lee, M.D., Editor. Phila. Bedell & Bro., Pubs. New York. pp. 40.

The Salutatory says that it "will strive to show that the conscientious practitioner preserves intact, the strict inductive method of Hahnemann; also that the following are the true and essential features of homœopathy: The Law of the Similars; The Single Remedy; The Minimum Dose."

THE MEDICAL CALL.—A Quarterly Journal devoted to the wants of the busy Doctor. Editors, Drs. W. D. Foster and O. H. Crandall. Quincy, Ill. pp. 31.

The initial number presents a favorable appearance, and we have no doubt the Editors will make good their intention to make it a "live Journal."

BILIARY CALCULI; PERINEORRHAPHY; HOSPITAL GANGRENE, AND ITS KINDRED DISEASES; with their Respective Treatments. By C. H. von Tägen M. D., late Prof. of Operative Surgery, Hom. Hospital College, Cleveland, O., and Hahnemann Med. College, Chicago, Ill., etc., pp. 154. Bœricke & Tafel, 1881.

The author of this little *brochure*—whose recent decease is so much to be lamented—is well known to the readers of this Journal, to which he was so frequent a contributor, as a painstaking and careful observer; and the volume which he leaves to his memory will be sought and read by all who are interested in the subjects of which it treats. The work is exhaustive, and the portions referring to the "therapeutics of Biliary Calculi" and "the use of *Bromine* in Hospital Gangrene," are alone worth the price asked for the whole. The book should find its way into the library of both the physician and surgeon.

HAND-BOOK OF SYSTEMATIC URINARY ANALYSIS, CHEMICAL AND MICROSCOPICAL, for the use of physicians, medical students, and clinical assistants. By Frank M. Deems, M. D., Labaratory Instructor in the Medical Department of the University of New York, New York. The Industrial Publication Co., 1881.

This little work for the systematic examination of the urine, step by step, both chemically and microscopically, is prepared with the intention of supplying students of medicine, clinical assistants and practitioners with a concise guide, which, from its small compass and tabulated arrangement may serve both as a bedside reference book and a work table companion. The writer shows an intimate knowledge of his subject and a ready tact in instruction. The result is an exceedingly valuable little compend, which must have a large and ready sale.

CORRESPONDENCE.

MESSRS EDITORS:—In your January number, page 225, Dr. Eldridge C. Price in an article on "Our Materia Medica," misquotes a line from Lilienthal's Therapeutics. Dr. Price says:

"I find in Lilienthal's Therapeutics, last edition, p. 91, *Cæsium* recommended by Baruch for *pain in the left testicle*. There is no trustworthy proving of *Cæsium*; then where did he get this symptom? It must be of clinical origin; and yet we find it without any *distinctive mark* among other remedies purporting to have been 'weighed in the balance and not found wanting.'"

Page 91, it reads "BILIARY CALCULI"—*Cæsium*, (Baruch).

Is not naming the authority a distinctive mark? Just as I did it in yellow fever with Dr. Hardenstein and at other places; where I could not verify the symptom from "Our Materia Medica;" but how did that pain in the left testicle come into Dr. Price's imagination?

Dr. Baruch is by his friends considered such a high authority on "Our Materia Medica" that I fear, some overzealous student might incorporate *Cæsium* and pain in the left testicle in his Manuscript Repertory, and hence the disavowal.

By inserting this rectification, you oblige greatly,

Truly yours,

S. LILIENTHAL.

CORRIGENDA.

BY ELDRIDGE C. PRICE, M.D.

In the article "Our Materia Medica," which may be found in the January number of the TIMES, I state: "Even Gilchrist and Allen confuse drug identity;" and in a foot note I refer to *Nux* and *Angustura*.

I wish to withdraw this statement—contingent upon certain possibitities—for the following reasons: In October last, when I had written the article in question, I destroyed the few notes I had taken from various sources, and the substance of which I used. My authority for the assertion is, unfortunately, among these notes. The statement was taken from some one of our numerous journals, and I was so well satisfied of its author's veracity that I did not at the time think it necessary to verify his assertion. As well as I remember, but one symptom was criticised; and as I cannot now recall the symptom, and can offer no authority for my statement further than I have given, I deem it due both Gilchrist and Allen to withdraw it.

If, however, at any time in the future I discover my lost authority, I consider it only due to myself to withdraw my recantation.

And now a few words about another error, and this time Dr. S. Lilienthal is implicated. I state, as a fact, that the symptom "pain in the left testicle" is mentioned on p. 91, Lilienthal's Therapeutics, 2d edition, with Dr. Baruch's name appended as authority, when, in reality, no such symptom is there mentioned. Dr. Lilienthal says (correspondence department of this number of the TIMES): "Page 91 it reads, 'Biliary Calculi'—*Cæsium* (Baruch);" and again, "But how did that pain in the left testicle come into Dr Price's imagition?"

Now "hereby hangs a tale" which I will proceed to narrate, *viz.*:—A controversy occurred a few months since in the N. A. J. of H., between Dr. Wm. E. Leonard, of Minn., and the writer about a certain proving of *Cæsium*. Being the editor of this journal, Dr. Lilienthal may recall the articles published upon this subject.

In the argument I criticised a symptom of the testicle, supposed by Dr. Leonard to have been produced by *Cæsium*. He says: "Prof. Farrington tells me of a cure by *Cæsium* 24ᵐ of the very symptoms in the right testicle to which Dr. Price objects; and that after a variety of other homœopathic medication. And this accords precisely with the effects of *Cæsium*, as known by Dr. Baruch, of New York. He has used the drug for spinal irritation, worse in the lumbar region, with *irritation of the testicles*, weakness of the legs, etc. See also Lilienthal's Therapeutics (2d edition), p. 91, where *Cæsium* is recommended by Dr. Baruch, for biliary calculus."

Now this is just how the pain in the left testicle came into my imagination. By nature I have a good memory, and in this case I depended entirely upon it; it played me false, and, by a process of substitution, you see the result. This is the only excuse I have to offer.

Since we are upon the subject of *Cæsium*, let me suggest that it is quite possible for the "biliary calculi" to fit the testicle-symptom niche equally well. Referring to p. 91, of Lilienthal's Therapeutics, we do find, as Dr. Lilienthal says, *Cæsium* recommended for biliary calculi. But why should the drug be mentioned as preeminently superior to the group of twenty-three drugs among which it stands? Does the endorsement of one man only, no matter how high an authority he may be, place a drug so little known as *Cæsium* upon the pinnacle it occupies in this work? Have all the other remedies mentioned been proved and verified less than *Cæsium*? If such is the case, then we must truly lament the reliability of this group of remedies.

Another point I must not overlook, which will apply to *Cæsium* for biliary calculi equally as well as to *Cæ-*

ium as a testicle remedy, and it is this: I state that we find *Cesium* "without any *distinctive* mark, among other remedies purporting to have been 'weighed in the balance' and not found wanting." Dr. Lilienthal asks: "Is not naming the authority a distinctive mark?" thus rendering an entirely erroneous interpretation of my meaning. When I spoke of a "distinctive mark," I meant a distinctive mark of *inferiority*, not of superiority; and I did not for a moment suppose anyone would have misunderstood me as Dr. L. has done.

Cesium should have been placed at or near the end of the list of remedies, and not given the prominent position it now occupies.

Having corrected my errors, the article "Our Materia Medica" should be read with the following alterations: Substitute "biliary calculi" for "pain in the left testicle," and erase entirely the sentence relative to Drs. Gilchrist and Allen, with its appended footnote

I most deeply regret that such mistakes should have occurred in an article which was written in the sincerity of an honest purpose; I hope, therefore, that Drs. Gilchrist, Allen, and Lilienthal will consider my explanations a sufficient correction of my statements.

SOCIETIES, ITEMS, ETC.

NEW YORK COUNTY SOCIETY.

The following Bureaux have been announced:—

MATERIA MEDICA AND TOXICOLOGY.—To report February 9th. Wilson Peterson, M. D., *Chairman*; T. F. Allen, M. D., Edward Bayard, M.D., Mary E. Bond, M.D., J. T. O'Connor, M.D., Joseph Finch, M.D., Amelia Wright, M.D., H. von Musits, M.D., C. Lippe, M. D., O. R. King, M.D.

CLINICAL MEDICINE AND PSYCHOLOGY.—To report March 9th. William J. Baner, M.D., *Chairman*; J. G. Baldwin, M.D., J. W. Dowling, M.D., F. S. Bradford, M. D., Alex. Berghaus, M.D., G. C. Brown, M.D., J. P. Ermentraut, M.D., J. H. Demarest, M.D., W. H. Krause, M.D., J. H. McDougal, M.D., F. Oertel, M.D., H. H. Tinker, M.D., Geo. E. Tytler, M.D., Thos. Wildes, M. D., Stephen W. Goodrich, M.D., A. R. Adams, M. D. PSYCHOLOGY.—E. P. Fowler, M.D., S. Lilienthal, M.D., A. P. Williamson, M.D., Bukk G. Carleton, M.D.

PHYSIOLOGY, PATHOLOGY AND HYGIENE.—To report April 13th. Geo. M. Dillow, M.D., *Chairman*; J. McE. Wetmore, M.D., H. B. Millard, M.D., S. Swan, M. D., J. S. Linsley, M.D., Louise Gerard, M.D., J. de la Montagnie Lozier.

SURGERY AND ELECTRICITY.—To report May 11th. F. E. Doughty, M.D., *Chairman*; Wm. Tod Helmuth, M.D., John C. Minor, M.D., John H. Thompson, M.D., E. Carleton, Jr., M.D., H. I. Ostrom, M. D., A. T. Hills, M.D., E. Guernsey Rankin, M.D., Emma B. Ryder, M. D. ELECTRICITY.—John Butler, M.D. GENITO-URINARY. —Geo. W. Blodgett, M.D.

ZYMOSIS AND DERMATOLOGY.—To report June 8th. Egbert Guernsey, M.D., *Chairman*; H. B. Millard, M.D., Wm. H. White, M.D., P. E. Arcularius, M.D., J. M. Schley, M.D.

OBSTETRICS.—To report September 14th. F. J. Nott, M.D., *Chairman*; S. P. Burdick, M.D., R. McMurray, M.D., C. E. Blumenthal, M.D., Chas. E. Campbell, M. D., J. Robie Wood, M.D., Wm. M. Pratt, M.D., H. M. Hitchcock, M.D., P. J. B. Wait, M.D.

EYE, EAR AND THROAT.—To report October 12th. Chas. Deady, M.D., *Chairman*. EYE.—C. Th. Liebold, M.D., Geo. S. Norton, M.D., D. B. Hunt, M.D., F. H. Boynton, M.D., Chas. C. Boyle, M.D. EAR.—H. C. Houghton, M.D., Wm. E. Rounds, M.D. THROAT.—J. M. Schley, M.D., C. E. Beebe, M.D.

GYNECOLOGY AND PÆDOLOGY.—To report November 9th. N. A. Mosman, M.D., *Chairman*; Geo. E. Belcher, M.D., B. F. Joslin, M.D., L. L. Danforth, M.D., W. O. McDonald, M.D., Mary W. Noxon, M.D., Mary H. Everett, M.D., A. B. Cossart, M.D., Walter Y. Cowl, M.D., C. H. Moore, M.D. PÆDOLOGY.—W. N. Guernsey, M.D., Thos. Franklin Smith, M.D., St. Clair Smith, M. D., Mrs. J. G. Brinkman, M.D., M. Deschere, M.D.

STATISTICS.—E. M. Kellog, M.D., *Chairman*; Henry M. Smith, M.D.

LEGISLATION.—J. W. Dowling, M.D., *Chairman*; Edward Bayard, M.D., Egbert Guernsey, M.D., Joseph Finch, M.D., O. R. King, M.D.

NECROLOGIST.—Henry D. Paine, M.D.

COMMITTEE ON MEDICAL INSTITUTIONS. — A. P. Williamson, M.D., *Chairman*; Geo. M. Dillow, M.D.

LIBRARY COMMITTEE —H. I. Ostrom, M.D., E. Carleton, Jr., M.D., Arthur T. Hills, M.D.

ALLEGHENY COUNTY, PA., MEDICAL SOCIETY.

DISCUSSION ON "DISEASES OF THE MONTH"—JAN. 14.

Dr. Childs: I am now treating a case of post-scarlatinal dropsy in a child, where the previous course of the disease had been comparatively mild. The throat symptoms were slight, and the desquamation light. While convalescing, the child took cold and dropsy appeared, but not in a severe form. Examination of the urine showed the presence of albumen. *Apis*, followed later by *Lyc.*, was given. I did not see the child for one week. At this time I found the urine high colored, and containing what seemed to be decomposed blood corpuscles. Physical examination of the urine showed it to be heavily charged with albumen, and blood corpuscles present. *Terebinthina*[3] was given. This is really the fourth attenuation, since the article sold for the tincture is in reality about the first attenuation. This remedy acted very promptly in correcting the pathological condition present. Afterwards, for light-colored stools, with early morning aggravation, *Pod* was given. The dropsical condition extending towards the chest, *Apocy.*, gtts. x, to aq ℥ ii, was given. The child had been also several times thoroughly anointed with cosmoline, placed in a hot bath, and, when taken from the bath, wrapped in a hot dry blanket, and with a gloved hand under this blanket, was again greased with the cosmoline. Following this treatment the tissues of the extremities became softer and there was more moisture on the skin; she rested better, and was less fretful. She still having a voracious appetite and light stools, on the recommendation of Dr. McClelland, *China* was given. The sounds of the heart were slightly muffled in the beginning, but are now clear.

Dr. McClelland: One potent cause in producing this condition is the extreme dryness of the skin from the fever; its function is nearly destroyed, so far as secretion is concerned. The kidneys are correspondingly overtaxed, and the congestion already existing is increased. The diseased kidney causes the dropsy. I always have my patients freely and frequently sponged, even during the continuance of the fever, where it can be safely done. During convalescence, when desquamation begins, I have the patient oiled with vaseline, cocoa butter, or similar substances, and then sponged off with soap and water. In the cases where I have followed this plan there have not been any dropsical symptoms. I saw a few days ago, while at Newcastle, four cases of post-scarlatinal dropsy. The skin of each patient was as dry as parchment. There had not been any bathing or lubricating, and I think as a result dropsy followed. One of these cases manifested a peculiar train of symptoms. The patient was a young man about nineteen years of age. He had had dropsies

symptoms, but they had nearly all disappeared. On the 9th, feeling pretty well, he had eaten freely of canned salmon. He was seized in the night with attacks of vomiting, which continued into the next day and began to have a fæcal odor. I saw him in consultation on the 11th, and found him in a state of collapse. He was thirsty and drank largely, but by actual measurement did not drink half as much as he vomited. There must have been three pints of a dark bottle-green fluid discharged at a time; it gushed forth as though forced from a pump. He would have intervals of one or two hours when he was free from vomiting. This attack had continued for forty eight hours when I saw him. His skin was shrivelled like one in the collapse of cholera, except that it was horny and dry, as though the serum of the body had been poured into the stomach. The bowels were constipated. I ordered free injections to be given, which removed a small quantity of fæcal matter which had remained in the lower bowel. I examined carefully, inch by inch, every part of the abdominal surface in order to detect, if possible, any signs of an invaginated gut or strangulated hernia. Nothing was found except a small mass in the umbilicus, about as large as a pea. I was not certain on account of the size whether it was simply connective tissue or a small piece of omentum; I, however, pressed it back into the abdomen. There was no tenderness or soreness even to rough handling. The temperature and pulse were normal. There had not been any pain before the vomiting began, and no localized soreness. The abdomen was flat, and the walls could be pressed back to the spine. I watched him through the night, and he vomited twice the amount of liquid drank. In the morning his pulse was pretty fair. I recommended the *Arseniate of copper*. I heard from him yesterday (the 13th), and he was about the same. He had had a slight movement of the bowels, but this was probably the result of the beef juice which had been ordered as an injection. What is the diagnosis? [Jan. 20. Dr. McC. reports as follows: This case terminated fatally on the 15th. The attending physician, Dr. D. R. Harris, made a post-mortem examination, which revealed the duodenum in a gangrenous state, but no actual obstruction existing, although the bowel must have been virtually closed at this point. The stomach contained six pints of the bottle-green fluid described above.]

Dr. Chapman: I have had a number of cases which seemed in many of their symptoms to point to the diagnosis of measles. The attacks would not last more than three or four days. The rash would appear among the very first symptoms. Some of the patients had sore throat, others congestion of the eyes with lachrymation. In two cases there was slight desquamation about the ears and neck. The cases occurred in children and in adults.

Dr. Ferson: In cases of scarlatina where the urine was dark and scanty, or continued scanty, after the temperature had subsided I have used rapid, but not hard friction, with a coarse towel. It seems to awaken reaction in the skin.

Dr. Selp: I have used *Apocy. can.* in post-scarlatinal dropsy, but have no positive indications for its use. I generally use it after *Apis*, where no result has been obtained by the use of that drug, although seemingly indicated. Dr. Hofmann uses the tincture, or first decimal, in water. Early in the convalescence from scarlatina I use the warm baths. This seems to promote the functional activity of the skin, especially if the skin is greased after the bath. I use very little friction.

I have met a large number of cases of the disease spoken of by Dr. Chapman. It is called among the people "three days" or "Dutch" measles. The disease is technically known as "Rötheln," and occurs frequently in Europe, especially in Germany. There have been a few epidemics of the disease in this country, notably one in Boston and another in New York (see Smith's Dis. of Children, Art. Rötheln). The first case that I met this year was during the holidays, in a young man about sixteen years of age. His eyes were congested and lachrymose; tongue coated; slight cough and sore throat; pulse and temperature varying but little from the normal state. I knew that he had had measles, and my first thought on looking at the case was of urticaria; but the elevated ridges of that disease were wanting. Since then I have seen cases nearly every day—my own children among the number. The prodromal stage is slight or unnoticed; many children go to bed well, and next morning the eruption will be abundant. In one of my children it did not appear until after the face had been washed, when it came out abundantly. Others go to school free from all symptoms, and the eruption will appear during school-hours. In some cases the eruption is discreet, in other cases it is more nearly confluent. In some cases the patches are redder than others, and give a mottled appearance to the skin. Vomiting is a frequent complication, and at times considerable itching. The latter is relieved by warm baths. The mucous membrane does not seem to be very much affected. One of my cases was followed by diphtheria. This was the experience in the epidemic in New York. I have used *Bry. Apis., Rhus, Arsenicum.*

My first experience in this disease was about three years ago, when two children who were attacked had previously had scarlatina and measles. Although the disease is usually free from dangerous sequelæ, one of the above-mentioned children died from cellulitis, affecting principally the neck and upper part of the chest

Dr. Burgher: In the form of dropsy spoken of, I think they are, in nearly every case, the result of exposure to cold. Light attacks of scarlatina are more apt to be followed by these troubles than the more severe attacks, and it is undoubtedly due to the greater degree of care exercised in the latter cases. It may occur in some cases before desquamation begins, but as a rule it occurs only when the stage of desquamation is pretty well advanced. Bathing, when properly performed, is of great advantage in restoring the functions of the skin, but care should be exercised in the use of friction.

Dr. Martin: Are not the kidneys congested in every case of scarlatina?

Dr. Burgher: I presume there is more or less congestion. Two children in a family under my care were taken sick in the early part of the winter with scarlatina. As soon as the first one was seized, an older sister was sent away from the house. The cases were isolated in an upper room, and attended only by the father and mother. These changed their clothing whenever they came from the room. All the furniture which could be spared from the room was removed, together with the carpet, which was freely washed with carbolized soap. The children were confined to the room several weeks after apparent recovery. Everything which had been used about the children was destroyed or soaked in a strong solution of carbolized water. The room was closed tightly for forty-eight hours, and thoroughly fumigated with sulphur. After the room was opened the walls were scrubbed with carbolized soap. Three or four weeks after this, the daughter who had been sent away came home, and she is now sick with the disease. The first children had no sequelæ, and but slight desquamation.

Dr. McClelland: In regard to the young lady injured in the 28th Street railroad accident (see TIMES, p. 213), I would state that she is now convalescing. There is, however, some tenderness on the spine, and the pulse is still rapid—100–110 per minute. [At the December meeting the report had been as follows: The disease progressed favorably for some days, with the exception of the high pulse; but from some indiscretion in diet there was a relapse. The temp. rose to 105°; pulse correspondingly high—160–170 per minute. The temp. has gradually decreased. She seems to be running through another course of fever. The pulse still keeps

up. The mind is perfectly clear. She suffers little or no pain.]

Dr. Ferson: A few nights ago I was called to a case of labor, and on examination discovered a complete placenta prævia; profuse hæmorrhage was also present. I called Dr. J. H. McClelland in consultation. The brim of the maternal pelvis was very much contracted. In order to effect delivery the hand was passed through the placenta, and the feet of the fœtus were grasped and brought down. The hips of the child lodged in the contracted strait, and powerful traction had to be made by means of the forceps before they were released. As the head came down it also caught; and as both blades of the forceps could not be applied, the head was spooned out, so to speak, by means of one blade of the forceps. After delivery, copious injections of warm water containing permanganate of potash were used. The highest temp. was 103¼; to-day it is 102¾.—(T. M. S.)

ANNUAL MEETING OF THE BOSTON HOMŒOPATHIC MEDICAL SOCIETY.

Reported by Horace Packard, M.D., Sec.

The comatose state in which this society has been for the last half decade seems to be a thing of the past, if any conclusion can be drawn from the interest shown at the last meeting, which convened the evening of Jan. 15 Not less than sixty members were present, besides several distinguished visitors from abroad, including Drs. Helmuth and Dowling from New York, von Gottschalk and Budlong from Providence, R. I., and Gallinger from Concord, N. H.

Three new members were elected, and ten names proposed.

The retiring President, Dr. de Gersdorff, read a paper, in which he lamented the frequent lack of appreciation by the laity of the best and most earnest efforts of the physicians.

The Secretary, Dr. Wheeler, made his annual report, which shows a membership of sixty-three; number of meetings during the year, nine; with an average attendance of about six. He closed by tendering his resignation. A committee of three was chosen, to nominate officers for the ensuing year. The result of their deliberations was as follows: Pres., M. P. Wheeler; Vice-Pres., H. E. Spaulding; Sec., Horace Packard; Treas., H. C. Clapp; Censors, C. H. Farnsworth, Conrad Wesselhœft, and F. N. Palmer, who were unanimously elected.

Dr Talbot reported in detail two operations for ovarian tumors and one for a large fibroid, in which the entire uterus and both ovaries were removed. The first two cases recovered without an untoward symptom; the third died on the thirteenth day, from phlebitis.

Dr. Helmuth made remarks on the theme introduced by Dr. Talbot, and said: 'There is no operation which gives the young surgeon such conceit as a successful case of ovariotomy, and none which takes it out of him more thoroughly than an unsuccessful one." He believes the greater percentage of successes the present day, is due to improved methods of operating and after-treatment, such as the carbolic spray and antiseptic dressing, the use of the thermo-cautery, drainage tube, and frequent irrigation of the abdominal cavity. He finds the expedient of turning the patient on her side while evacuating the contents of the cysts, a valuable one, thus avoiding all possibility of the ovarian fluid flowing back into the abdominal cavity. In sudden sinking of the vital forces, he injects a drachm or two of whiskey into the glutei muscles, with better success than per rectum. Out of his last seven cases he has lost but one.

Dr. Bell, recently settled in Boston from Augusta, Me., reported seven cases of ovariotomy, with five successes.

Dr. Dowling gave an interesting dissertation on hypertrophia cordis.

Dr. Gallinger, the medical politician from N. H., made a stirring address, in which he portrayed in glowing terms the advantages derived from medical legislation.

A sumptuous repast was served, followed by social conversation, addresses by Drs. von Gottschalk and Budlong, and a humorous poem by Dr. Helmuth. Extensive preparations are in progress for the next meeting, which will be held the eve of Feb. 10, and at which physicians will be cordially welcomed.

BROOKLYN MATERNITY.

We extract as follows from the ninth annual report, which shows the institution to be in a most flourishing condition:

"We extended aid during the year to 318 women and children, the family averaging 66 per month. We admitted to the lying-in wards 117 women—68 before confinement and 48 after. Of this number 7 were discharged before confinement and 87 after, some remaining with us, employed in the nursery or other parts of the house. Those discharged were from various causes. The husbands of some, securing employment, were thus enabled to care for them at home; in other cases the assistance of friends rendered our aid unnecessary. We note in this department the advent of twins, the fourth case of the kind in the history of the institution. There were seven deaths—two stillborn and five from other causes. The only adult death occurring in this division was one in which the disease was incipient at the time of her admission, and after her confinement developed rapidly. We thus note the continued remarkable exemption from sickness, which has always marked the history of the maternity, this being only the sixth death out of 827 confinements and 1,651 cared for, not one of whom died in labor. In the nursery and hospital we cared for 101 children, of whom 61 were born in the maternity, 19 admitted as boarders, 78 discharged, 4 deaths and 2 adoptions; and at time of preparing our report we had remaining with us 23, whose continued good health bears testimony to the care and attention they receive. We have furnished 9 wet nurses and employed in our own nursery 49.

"We were enabled, through the kindness of Mr. Douglas and the Brooklyn, Bath and Coney Island Railroad, to send the older children to the Seaside Home at Coney Island, for a week's "outing," the beneficial result of which was told upon their return by the rosy cheeks and merry hearts. We admitted in training school six students, of whom five received certificates on the evening of October 8, one of the class having been dismissed for untruthfulness, unreliableness and general incompetency. This is the first class graduated since the school term was extended to one year, and we feel assured their efficiency will attest the wisdom of the step. Six former graduates received diplomas.

"The total number of graduates is 41, a few of whom have died, some have married and given up the profession, one had her certificate cancelled and at present time 34 are giving satisfaction to both physicians and employers, and to be a 'Maternity nurse' carries with it its own recommendation and secures employment.

"We have recently added to our committees an Investigating Committee, whose duty it is to familiarize themselves with the history of every one admitted to our care, with the view of ultimately helping them.

"The financial condition, as set forth by the treasurer's report, shows receipts $8,277.93 for the year, while the expenditures have been within $55 of that sum."

It is reported that "Locomotor ataxia" has been cured by stretching the sciatic and crural nerves.

ORANGE CO. HOMŒOPATHIC MEDICAL SOCIETY.—A quarterly meeting of the Orange Co. Homœopathic Medical Society was held at the Asylum January 11th, 1881.

Dr. Talcott, President of the Society, occupied the chair and called the meeting to order.

The minutes of the last meeting were read by the Secretary, Dr. Ira S. Bradner. Representatives of the Society were present from Port Jervis, Middletown, Goshen, Cornwall and Montgomery.

After reading the minutes the following papers were read before the society:

"Restraint or non-restraint in the treatment of the insane," by Dr. Selden H. Talcott, Superintendent of the Asylum.

"Cellulitis, its nature, causes, pathology and treatment," by Dr. C. Spencer Kinney, assistant physician at the Asylum.

Dr. A. M. Woodruff was nominated for permanent membership in the State Homœopathic Medical Society.

Dr. C. Spencer Kinney was elected a delegate member of the Homœopathic Medical Society.

After a brief discussion of minor matters the society adjourned.

ON THE DETECTION OF ALBUMEN IN URINES.

BY J. EDWARDS SMITH, M.D.

Prof. of Histology and Microscopy, Hom. Hospital College, Cleveland, Ohio.

The test for albumen given in your January, 1881, No. (page 102), may, for two reasons, lead to serious error.

First: Should the specimen treated contain urea in excess, its contact with *nitric* acid will cause a heavy precipitate—not of albumen, but of nitrate of urea. Again, if so be that the specimen happen to contain urea largely in excess—say 30 grains to the fluid ounce—its contact with *nitric* acid will result in the forming of a solid mass, consisting of crystals of the nitrate of urea.

Second: If the thin glass cover be not warmed by the process mentioned in the paragraph referred to, then, should the urine be rich in earthy phosphates, will occur a precipitate of the same, which might easily be mistaken for albumen.

In all cases when the methods given on your page 102, or those which follow, have been employed, any precipitate thus obtained should be examined under the microscope and its character determined, as is customary with professional microscopists.

A daily experience for years in working over urines has taught me that no one test for albumen can be decisive. In my own practice I daily use four tests, which I gladly present for the consideration of your readers.

First: The well-known heat and *nitric* acid test, known to all, yet seldom properly performed. Proceed as follows:

Take a perfectly clean test tube—see that it is perfectly clean—place therein a little of the specimen to be tested; heat to the boiling point, wash the outside of the tube at the part containing the urine well under the tap, and without drying examine. If no turbidity appears, the presumption is that there is no albumen present—which can be detected by this process. If, however, turbidity exist, bring to the boiling point once more, add a few drops of c. p. *nitric* acid, wash again under the tap, and re-examine. If now a precipitate still remain, the presumption is that there is albumen present. On the contrary, should the urine "clear up" under the acid, it is to be presumed that there is no albumen detectable by this method. In using this test, never add the acid until after the boiling. This test is applicable to all urines having an acid reaction.

Second: Should the urine be alkaline, proceed as follows: Place in a clean test-tube as before, and make acid with *acetic* acid; boil, wash under the tap as before, and examine; any turbidity present is suggestive strongly of albumen. Always add the *acetic* acid before the boiling.

Third: Suitable to urines acid or slightly alkaline. To a little urine in a test-tube add one-third its bulk of *acetic* acid. Shake well, and further add a few drops of a solution of the *ferro-cyanide of potassium.* If albumen be present, turbidity will ensue. This test requiring no heat, can be readily performed in the sick room, and, by the way, is one of the most delicate tests.

Fourth: For acid urines. In a small test-tube—say about the size of a thermometer case—place about thirty drops of urine; be sure to use a clean tube, outside and in. Hold the tube obliquely—say at an angle of forty-five degrees—and allow two or three drops of c. p. *nitric* acid to run down the inner surface of the tube. Being heavier than the urine, the acid will seek the bottom of the tube, displacing the urine. Bring the tube carefully to an upright position; holding now the same to the light, the clear acid may be seen at the bottom. If albumen be present, the coagulum will commence at the top surface of the acid, and gradually extend upwards to the surface of the urine. If so be that the specimen be heavily charged with the earthy phosphates, it is quite possible that the *nitric* acid may throw these out of solution, in which case the cloudy precipitate will commence near the surface of the urine and gradually work downwards towards the acid.

Of these four tests, the last one in my hands is the most delicate. I have many times dealt with urines which totally defeated the first three tests named, and yet surrender without opposition to the last named.

It is sometimes very important to detect quantitatively the presence of albumen, as the process by volumetric chemistry is somewhat complex, requiring considerable time, as well as a delicate balance. I will now give a process of my own, which is quite accurate enough for the purposes of the "busy practitioner"—to wit:

To arrive at the amount of albumen to the fluid ounce (456 grs.), first procure a Marais "approximate test-tube." These can be easily procured of the dealers. It is simply a large test-tube furnished with a foot. The lower part of the tube is graduated into fifths of centimeters, while the upper part has a line denoting the level of the surface of a fluid ounce. Also provide a large test-tube capable of holding at least 1¼ ounces of liquid. Now proceed as follows:

Fill the "approximate tube" to the ounce-mark with the urine to be examined. Transfer this to the other tube and boil well; add five or six drops of c. p. *nitric* acid, boil again, and placing the tube obliquely under the tap, so that no water shall enter, allow it to cool to an extent that may not endanger the "approximate tube." Shake well and transfer back again both coagulum and liquid to the "approximate tube," and set the same one side for twenty-four hours. Now read off the height of the coagulum. Every two whole centimeters will equal one grain of albumen to the fluid ounce of urine.

Note: Physicians usually call for the first urine passed in the morning, *i. e.*, the *urina sanguinis.* It should, however, be remembered that such specimens may be totally free from albumen, when a sample passed during the afternoon hours may contain seven or eight grs. of albumen to the ounce. I have met with repeated examples of this.

Much more remains to be said, but time and space forbid. The growing importance attached to intelligent chemical and microscopic examinations is my excuse for thus far trespassing on your valuable journal.

A SURE sign of pregnancy during the first three months is said, by a careful observer, to be found in the deep violet blue color of the mucous membrane of the vagina and cervix uteri.

CASES FROM THE PRACTICE OF H. C. FROST, M.D., BUFFALO, N. Y.

Max Walters, aged 53, German, while repairing a well, fell from curbing to bottom, a distance of thirty feet, falling astride a strip of board which stood perpendicularly in the bottom of the well. The piece of wood was apparently a strip from an old hemlock fence board; it was five feet long, two and five-eighths inches wide, and one inch thick; rough, splintered, and covered with the slime that accumulates at the bottom of an old unused well. The piece of wood entered the scrotum, passed over Poupart's ligament, then up between the abdominal muscles and the adipose tissue, and from thence between the external muscles of the thoracic region and the adipose tissue to a point over third and fourth ribs, where it made its exit. The scrotum was divided so that the testicles hung without scrotal covering. About a foot of the stick protruded at the upper opening, surmounted with a piece of woollen cloth as large as one's hand, which had been torn from the pants and carried through the body on the end of the stick. It was probably this piece of woollen cloth, acting as a padding to the sharp and rough edges of the end of the stick, that prevented the piece of wood from entering one or both of the large cavities of the trunk. The track of the wound was much wider than the stick, as I afterwards found when suppuration had set in. After the accident, the man ascended the ladder to near the top of the well, from whence he was assisted to the house close by. Both ends of the stick protruded. It was thought by those who first attempted to relieve him of the sliver, that it merely passed through the clothes, until they had made several futile attempts at extraction. It was finally pulled out from below. There was no hæmorrhage to speak of. The spermatic cord was not injured. The wound was cleansed as much as possible, the scrotum sewed up, drainage openings left at both extremities of wound, and the abdomen and thorax snugly bandaged. After suppuration was fairly established, I was obliged to make openings along the abdominal track of the wound. On the twenty-fourth day the repair was complete. He was injured Oct. 3, 1880, discharged from the Buffalo Homœopathic Hospital Oct. 30, and walked from a carriage to the polls Nov. 2.

Removal of a Fibro-cartilaginous Tumor from Parotid Region, by H. C. Frost, M.D.—Charles Jaeger, aged 47, farmer. First noticed growth about thirteen years ago, it had slowly increased in size till Oct. 7, 1880, when I operated. It was then about the size of an orange, hard, somewhat movable, situated in front and below left ear. I made an incision the whole length of the tumor at its posterior border, and afterwards enlarged it by a short transverse incision from middle of first. It required considerable careful dissection, as there were several prolongations running down into the parotid gland. The hæmorrhage was pretty lively for a few minutes, but principally from numerous small veins. The patient made a good recovery, with the exception of some paralysis of the facial muscles on the left side, but this has since passed away. Probably some branches of the facial nerve were divided during the operation. The tumor was what is called fibro-cartilaginous, about one-fourth of it being well formed cartilage and the remainder tough fibrous substance.

Ill Effects from Section of the Optic-Ciliary Nerve.—M. Poucet (*Le Prog. Med.*) makes the following observations: Besides the exterior and nervous phenomena already well known, this operation practiced close to the bulb, gives rise to disorders which may be divided into three periods: 1. Transient troubles of the circulation, due to the anterior anastomoses, but giving rise to a peri-vascular migration of white globules in the lesion internal to the retina. 2. (From the 8th to the 30th day.) Inflammation of the divided vessels, extending into the interior of the retina, choroid and optic nerve: Papillitis, periarteritis, endarteritis. Slight fibrous organization of leucocytes in the vitreous body at the infundibulum of the optic nerve and along the vessels. 3. (18 mos.) Absolute sclerosis of the retina with pigmentary impregnation, either hæmorrhagic or choroidian. Passage of the pigmentary masses into the vitreous body.

These phenomena noticed on the eyes of animals chosen from among those the most healthy in appearance and whose eyes are clear, often acquire a degree of intensity sufficient to produce atrophy. In man, the choroidian desquamation, and the passage of the pigment molecules into the vitreous body, are generally followed by phthisis of the bulb.

Besides these chronic lesions, immediate inflammatory lesions are produced towards the posterior pole. They manifest themselves by the rapid degeneration of the retina and choroid in this region; the equatorial parts are relatively healthy. These direct troubles are attributable to the section of the arteries too close to the eye; the sclerotic resists this inflammatory process. They can be avoided by evading the muscular insertions and carrying back the section about 0.006 min (.234 ins.) from the bulb, which still gives sufficient security in the cutting of all the ciliary nerves. (T. M. S.)

An interesting analysis of the various modes of sensibility of the visual apparatus, the London *Times* reports, has been made by Mr. Charpentier. He has been experimenting by looking in darkness at an opaque screen in which were perforated three or four minute holes, quite near each other, but distinguishable when a moderate light shone through. Light was raised from zero on the other side; it was sometimes colored. The order of phenomena was proved to be this: The first action of the light entering the eye in very small quantity is in all cases merely to produce a diffuse luminous sensation not differentiated either as to color or as to form; with a greater quantity one gets the notion of color, if there be color in the light; and still more light is required to be able to resolve the luminous object into its different elements. Luminous sensibility is the most simple reaction; then comes chromatic sensibility, by which we distinguish color, and lastly, what the author terms visual sensibility, by which we distinguish form.

Dr. F. N. Otis says he has taught for the last six years, that when a gland is enlarged as a result of the chancroid secretion, suppuration is inevitable, but in experiments made last winter at Blackwell's Island he found that fifteen out of eighteen buboes were brought to resolution by using *Sulphide of Calcium* $\frac{1}{10}$ (*Hepar Sulph.*) every two hours. Dr. Otis has probably saved his reputation and his membership of "regular" societies by calling the drug *Sulphide of Calcium*. If he had said *Hepar Sulph.*, and that he found its pathogenesis in the homœopathic materia medica, what a thrill of horror would have run through the ranks of his profession!

Carbo Animalis and Toxic Salts.—M. d'Arsonville (*Le Prog. Med.*) has noticed that when animal charcoal is mixed with sulphate of copper, the former assimilated in part the copper. In filtering the mixture the copper does not pass through. The same result happens with the acetate. An injection of the sulphate of copper mixed with the charcoal is not poisonous. Other active substances, such as strychnine, lose their poisonous qualities when they are mixed with charcoal. (T. M. S.)

Location.—Address Wm. F. Miller, Butler, Butler Co., Pa., for particulars. The right man will do well in this locality.

THE PARASITE OF LEPROSY.—M. E. Gaucher (*Le Prog. Med.*) in examining the blood of a leprous patient, extracted it by a puncture from the tubercles and from spots on the body where there was no lesion, and found movable bacteria to be present in large numbers. Some were in the form of rods, some as isolated monods, and others in the form of a chain articulated to the number of two or three links. These were found most numerous in the blood taken from the tubercles, but they were still discernible in blood from other portions of the body, although in fewer numbers. Even after the specimens were absolutely protected from contact with outside germs, these bacteria developed into chains of articulated micrococci and into simple or branched filaments presenting the ordinary appearance of the mycelium of the common mushroom. (T. M. S.)

CARBOLIC ACID IN WHOOPING COUGH.—Dr. Oltramare (*Le Prog. Med.*) has been using the *Carbolic Acid* as a remedy in whooping cough, with almost uniform success. The remedy was given in the following preparation: *Acid phenic cryst.*, one gramme, *syrup of meutha*, 40 grs., *water*, 80 grams. Three to four teaspoonsful of this were given every day. At the end of four or five days, in many cases, the vomitings ceased, the number of paroxysms diminished one-half, and, in the most favorable cases, at the end of eight days, the cough had lost its peculiar characteristics and was replaced by a slight bronchial cough which soon disappeared. In one case, that of a little girl one year of age, the remedy could not be given internally, so the vapors of the remedy were used. A solution of 10 to 100 was used; 200 grammes of the crystalized acid were volatilized without any discomfort to the nurse or child. The effect, in this case although not so rapid as the others, was nevertheless marked, so that by the tenth day the paroxysms had diminished nearly one-half, and by the 32d day the cough had disappeared entirely. (T. M. S.)

NEURALGIA IN DIABETES.—M. J. Worms (*Le Prog. Med.*) calls attention to the attacks of neuralgia occurring in diabetic patients, and from them draws the following conclusions: First, there exists a form of neuralgia peculiar to diabetes, which is marked by its locating in the two symmetrical branches of the same nerve. Second, up to the present time, this neuralgia has been observed in the dental and sciatic nerves. Third, the diabetic neuralgia appears to be much more painful than other neuralgias. Fourth, it does not yield to the treatment usually adopted for neuralgia (*quinine*, *morphine*, and the bromides); it is aggravated and ameliorated according to the quantity of sugar present. The author groups these neuralgias in the class of dyscrasic neuralgias observed in gout, chlorosis, and lead poisoning. He leaves undecided, and to future researches, the question whether any alterations exist in the nerves or the neurilemma due to the saccharine fluids. (T. M. S.)

REFLEX TROUBLES IN THOSE OPERATED UPON FOR EMPYEMA.—M. Dumontpallier (*Le Prog. Med.*) has noticed, in two cases, grave and unexpected accidents several weeks after the operation, when a cure might have been considered as complete. The first case was that of a woman in whom M. D. was injecting the *tincture of iodine* through an opening in the throat. But a few drops had entered into the pleura, when the patient fell suddenly into a state of syncope; she remained several minutes without respiration, and, in order to reanimate her, it was necessary to make rythmical thoracic movements for the space of half an hour. Until the moment of the accident, the patient had tolerated the injections without any bad effects.

The second case was that of a man, forty years of age, who had been operated upon, eighty days before; the pleural adhesions had retracted the cavity to such a degree that only a very small quantity of liquid could enter it. At the moment when an injection of carbolized water was being gently thrown into the cavity, the patient was seized with a general contracture of the muscles of the opposite side of the chest. The contracture lasted several minutes and gave place to an incomplete paralysis.

M. Duret recalled in this connection, the experiments of MM. Reynier and Ch. Richet, who had observed the phenomena of contracture in consequence of the injections of irritant solutions into the larger serous cavities of animals. He thought that these phenomena were the result of a reflex action. (T. M. S.)

MEAT PARASITE.—In a report presented recently to the Academy of Sciences, M. Poincarré called attention to a new parasite which he had met in a number of pieces of beef. After describing the ordinary form of the parasite, which is cylindrical with two conical extremities, and which contains in the interior a granular mass, the writer asked if this should not be considered as an embryonic state of the tænia. M. Megnin (*Le Prog. Med.*) declares that this hypothesis does not seem to him to be admissible. This parasite, he thought, had been known before. Miescher found an analogous body in the muscles of a horse. M. M. has more recently examined many specimens of butcher's meat and has noticed parasite bodies in the meat of the *pot-au-feu*. These bodies are the same as those described by M. P., but we could not affirm that these foreign bodies were able to produce tænia. The "measly" cysticercus had not, in France, been found in beef. (T. M. S.)

A FOREIGN BODY IN THE RECTUM.—This foreign body was a bougie of stearine, and was nearly ten inches in length, the superior extremity of which, gave rise to a marked pointing between the epigastric and left hypochondriac regions; the lower extremity could scarcely be reached by the tip of the finger inserted in the rectum. The bougie was seized with the forceps, and removed without much difficulty, although it was slightly broken. The foreign body had given rise to very little trouble, the patient complaining only of some slight gastric symptoms, and an inability to leave his seat. The bougie had been in the rectum for eight days. (T. M. S.)

INTERSECTED SYMPATHETIC DILATATION FROM REMOVAL OF THE SUPERIOR CERVICAL GANGLION.—MM. Dastre and Morat (*Le Prog. Med.*) while experimenting upon the vaso-dilator nerves of the sympathetic, removed from a dog the superior cervical ganglion without disturbing the vagus. The animal soon recovered; so that in the evening he eat and acted as usual. Eight days after, the animal being slightly under anæsthetic influence, they cut the vago-sympathetic on the side from which the ganglion had been removed. The cephalic end of the nerve was then excited; but there was no effect produced in the vaso-dilatation of the buccal walls of the corresponding side. A marked redness, however, was produced on the side opposite to the one from which the ganglion had been removed. Now if we cut the remaining vago-sympathetic, we will not have dilatation on either side, showing that dilatation is accomplished through the sympathetic. The existence of this intercrossed reflex action is significant in relation to the knowledge of the course of the vaso-motor nerves in the bulb and cord. (T. M. S.)

THE TOXIC DOSE OF CARBONIC OXIDE.—M. Grehant (*Le Prog. Med.*), in experimenting upon this subject, exposed dogs, rabbits, and swallows to an atmosphere containing a portion of this gas. When the air contained only $\frac{1}{1000}$ portion of carbonic oxide, no injury resulted. In order to produce death in a dog, it was necessary for the air to contain $\frac{1}{100}$ part of the gas. There is, however, a difference in the resistance of the same

species of animal; thus, of two dogs from the same litter, one died in an atmosphere of $\frac{1}{1000}$, while the other resisted its effects until it was increased to $\frac{1}{100}$. The rabbit resists a high degree of poisoning, so that a rabbit respired for an hour in an air containing $\frac{1}{10}$ of the oxide; it succumbed on the morrow to an atmosphere of $\frac{1}{20}$. A very small amount is fatal to a swallow. One died at the end of an hour and forty minutes, in an atmosphere of $\frac{1}{1000}$; a second one remained in the same air for two hours without dying. Practically, M. Grehant thought, these animals might be used to determine the quantity of gas in a confined place. We should only need to place successively, into the suspected air, a swallow, dog, or rabbit, which might serve as barometers for the dosage of the gas.

The quantity of carbonized blood in the dog and rabbit was 6cc. of the corbonized oxide, in 100cc. of blood. All the animals submitted to the experiments respired regularly, by the aid of the valve of Muller. (T. M. S.)

Development of the Teeth.—MM. Pouchet and Chabrit (*Le Prog. Med.*), in examining the teeth of a fœtus of an elephant in the *Jardin des Plantes*, have concluded that the general opinions on this subject are not exact. Since the works of Robin and Kölliker, it has been assumed that there is produced upon the surface of the gum an epithelial bud (bourgeon), which sends downward a prolongation destined to form a temporary, or "milk" tooth; this is the adamantine organ, or enamel of Kölliker. From the neck of this process, or organ, a second prolongation is given forth at a later date, and forms the permanent tooth. The more recent experiments seem to prove that the permanent teeth are not given forth from the neck of the temporary ones; there is no secondary adamantine organ. The primary epithelial bud, that M. Pouchet calls the epithelial plate, remains after the appearance of the temporary teeth, and gives birth also to the permanent teeth. In the elephant, where there is no second growth of teeth, the same plate or layer appears, together with the same prolongations. The two faces of the epithelial prolongation do not have the same structure; the inner surface is composed of cylindrical cells; while, in the outer face, there is a mingling of the epithelial cells with the tissue cells. (T. M. S.)

Secondary Syphilitic Laryngitis.—This complication is frequently present in syphilitic subjects. The tongue may be swollen throughout its whole extent, or only a portion may be affected. If the tumefaction is general the disease represents a severe form, between secondary and tertiary syphilis. The ulcerations, which are almost always under the form of erosions, are ordinarily located on the tumefied surfaces, but occasionally upon the papules. They are most frequently found on the epiglottis, and especially upon its free border. At times the tissues become indurated and degenerate in a marked manner. The treatment should be internal as well as external (cauterization with *Nitrate of Silver*). (*Le Prog. Med.*)

Dr. Landouzy (*Le Prog. Med.*) recommends an hypodermic injection of distilled water containing a few drops of cherry laurel water, for the exhausting paroxysmal coughs in those suffering from phthisis.

Cold Baths in Cerebral Rheumatism.—M. Wollez (*Le Prog. Med.*) gives us the characteristic signs of cerebral metastases in rheumatism, the delirium, the disappearance of the disease from the joints, and the increased temperature. From numerous statistical facts, collected from all sides, relative to the action of cold water in cerebral rheumatism, he concludes that the greatest reliance can be placed upon the efficacy of this therapeutic measure which is contradicted neither by salicylate of soda, sulphate of *quinine*, nor other medicaments to which recourse is had in the treatment of this disease. In these cases refrigeration gives the most unlooked for results, so that we should not hesitate to make use of it, whenever we meet a case of this kind. The means employed are multiple and consist of lotions and affusions; but M. W. prefers immersion. The bath should be repeated at regular intervals and at a temperature of 68° F. The writer usually prescribes a bath every three hours, and continues it for a variable time, which the first appearance of a chill alone will determine. In these cases the physician must permit his patient to die or conquer the prejudices of clients and the public by prescribing a cold bath in cerebral rheumatism. (T. M. S.)

The Temperature of the Surface of the Chest in Health and in Pneumonia and Acute Pleurisy.—M. Paul Redard (*Le Prog. Med.*) gives the following experimental results: 1. *In the Physiological state*, the skin of the thorax, as well as that of other regions, yields to marked variations of temperature. It is sufficient to expose the skin to a chilled air of 50° to 60° for two or three minutes to cause the temperature to fall from 1° to 2°. If we cover the skin, over a limited space, by clothing or wadding, there will be a noticeable rise in the temperature.

If a thermometer covered with wadding, cloth or a rubber band, is applied to the skin, the temperature rises during 20–25 minutes, and approaches the temperature of the central points. By applying more or less wadding, or pressing more or less upon the bulb of the thermometer, the temperature will vary from 5° to 6°. In such cases we do not get the exact temperature of the cutaneous envelope, but obtain too high a result. We create an atmosphere of confined air around the thermometer and the results are tainted with error. Rubbing the skin, pressure for a certain length of time, lying upon one side, will produce elevations of temperature of 5°, lasting for 20–25 minutes. The mean temperature of the chest in a normal state is from 92.8° to 93.2°; a sum slightly less than that afforded by other observations. It is extremely rare to find an equality of temperature between the two sides of the chest. In almost all the subjects of experiments, there existed the difference of 3°, 4°, 5°, and at times, 1°, between the two sides; the mean was 4°. No rule exists for determining which one of the sides is normally and always warmer than the other. There exists at the point of the heart a temperature slightly more elevated than on the right side. There is no elevation of temperature on the back along the course of the aorta. The temperature of the different points of the chest is nearly equal; more elevated at the summit. Compared with the temperature of the axilla; the peripheric temperature on the skin of the chest is lower by an average of 3° to 3.5°.

If the peripheric temperature is taken upon the same subject at different times of the day and at the same points, we notice, inversely to that observed almost constantly in the axillary temperature, that the sums of the peripheric temperatures obtained are not always the same.

We have also observed that by placing the hand in the air or cold water at 50° to 53° F., the temperature of the chest and axilla varies. It mounts higher on one side than the other; in some cases it may even descend on the chilled side and ascend on the other.

II. *In Pneumonia and Pleurisy.* The temperature of the affected side was compared with that of the opposite side at a level with the inflammatory condition.

The researches in the comparison of temperatures are rapidly made by means of a thermo-electric apparatus. The two thermo-electric plates attached to a galvanometer are placed upon two symmetrical points of the thorax, and the deviations of the needle observed. We are able to detect, in a short time, by moving the plaques, if any difference of temperature exists, not

only at the diseased point, but in the whole extent of the chest, and even in the trunk, superior members, etc.

From numerous explorations, practiced upon patients attacked with pleurisy and pneumonia in full evolution, we find that the peripheric temperature at the point of greatest inflammation of the pleura and lungs is equal, in a great number of cases, to that of the opposite and healthy side. Frequently there exists a difference of .2° or .3°, in some cases there is an elevation of from .3° to .4° on the sound side. It is not rare to find, in pneumonia, elevations of temperature on the side attacked, but, in such cases, the elevation exists not only at the inflamed point of the lungs, but in the whole extent of the chest, axilla (as observed by Gubler), at the point of the shoulder, and even on the loins. The elevation of the temperature of the diseased side in these cases is 1°, 1.5°, and even 2°.

In pleurisy we find the elevation of temperature on the side affected, less often than in pneumonia. We have, besides, verified the fact that in cases of febrile affections (pneumonia, pleurisy), with a general elevated temperature, the peripheric temperature tends to approach the central temperature and to run parallel with it. If the axillary temperature, for example, is 102.2°, the peripheric temperature of the skin of the side attacked is 99.5° to 100.4°. In none of our experiments have we found the temperature of the thoracic wall superior to the central temperature of the axilla and rectum. (T. M. S.)

Our school was ably represented at the recent meeting of the American Public Health Association, at New Orleans. Dr. J. P. Dake says it was a most interesting occasion, and urges the members of this school to take a more active part. Dr. B. W. James read an important paper, and Dr. M. T. Runnells, who has worked so assiduously to improve the water supply of Indianapolis, represented his State, by appointment of Governor Gray. Thus we see the barriers gradually subsiding, and members of the two great schools in medicine sitting together in harmony, for the consideration of subjects upon which there can be no serious difference of opinion, as medical men.

Drs. C. G. Raue, C. B. Knerr, and C. Mohr, literary executors of the late Dr. Hering, and editors of the Memorial Volume, announce that the material is already in hand, and awaits the necessary funds for publication. The profession in general are invited to contribute such sums as they feel inclined, for which they will receive a copy of the book when issued It is greatly to be hoped that the funds will be promptly forthcoming, and the editors will make due acknowledgements.

President Dowling announces that the Committee of Arrangements have decided upon Brighton Beach Hotel as the place, and June 14th to 18th as the time, for holding the next meeting of the American Institute of Homœopathy. Ample facilities are at hand for the accommodation and entertainment of all. The occasion promises well, and will not interfere with the International Congress, to be held in London July 11th to 18th.

We are most happy to announce that Dr. N. Emmons Paine, late of the Middletown Asylum, has so far recovered as to be able to take the trip across the water, and will winter in Italy. He has the best wishes of a host of friends.

Our esteemed colleague, Surgeon-General Wm. H. Watson, of Utica, has been appointed Regent of the University of the State of N. Y., in place of Chancellor Benedict, deceased.

Dr. W. H. Caine, of Stillwater, Minn., has been appointed County Physician.

The *Electrician* describes a microphone, invented by M. Boudet, of Paris, which transmits articulate speech very distinctly without altering the tone or causing any scratching noise. It is composed of a mouthpiece of the usual telephone kind, joined to the end of a glass tube, a centimètre in diameter, which is mounted on a jointed stand. The mouthpiece contains an ebony plate, one millimètre thick, to which is attached a piece of copper, penetrating the glass tube a little distance. In the tube are six carbon balls. At the end of the tube there is a piece of copper, which imparts the necessary degree of pressure to the carbons In its action this microphone of multiple contacts is like an ordinary middle-sized Gaiffe microphone, with six elements—peroxide of manganese and chloride of zinc—set up with a resistance of 800 ohms, with a Bell telephone for the receiver.

At a late meeting of the French Academy of Sciences, M. Durand read a paper on a method of producing speech in electric condensers, and particularly in the singing condenser. He connects one pole of the battery with one end of the induced wire of the coil, the other pole with one armature of the condenser, while the second armature is attached to the other end of the induced wire. In the circuit of the primary coil a battery and a carbon microphone are introduced. In this way speech may be produced with great clearness. The condenser which gave the best results was 0.06 metres in length of side, and contained 36 sheets of tinfoil. For the auxiliary battery two or three Leclanché elements gave weak articulate sounds. The intensity increases with the increase of the number of elements, but not proportionally. The current of the auxiliary coil does not traverse the condenser.

Dr. Williamson, Chief of Staff, reports the death rate of the Homœopathic Hospital, W. I., for January, 1881, at 3.60% and 583 patients treated.

Dr. Rollin R. Gray has removed from Brooklyn to 138 W. 23rd St., N. Y.

It has been predicted that Asiatic Cholera will prevail epidemically the coming summer.

OBITUARY.

Died.—E. C. Beckwith, M.D., at Columbus, Ohio, Nov. 21, 1880, of ulceration of the stomach.

Dr. Beckwith was well known to the profession, and a man of eminent ability.

A most pleasant and unusual feature of the funeral, was the eloquent eulogy by his brother, the genial Prof. S. R. Beckwith. We are glad to note this innovation to the often unnecessary melancholy, which pervades such service! No sweeter tribute can be paid our dear departed, and none better suited to perform it, than those who know them best.

How often have we listened to the cold emptiness of remarks of those to whom the deceased was unknown, and how sadly have we taken our leave!

Would that others would take example from this occasion, and make our funerals not only an honor, in remembrance of our departed, but also afford such consolation as is possible to aching hearts, and awaken the dormant courage in some depressed spirits yet in the flesh.

Let us take a less superstitious view of death, and our funerals will be shorn of much of their gloom!

Died.—John L. Clarke, M.D., of Fall River, Mass., aged 68, of pneumonia.

We can add nothing to the grand obituary of one who had known him for forty years: "He died full of honor, with the record of a spotless life, and one full of kind and useful services to his fellow-men."